THURSDAY 6TH FEBRUARY

19:00-21:00  PRECONFERENCE SATELLITE MEETUP WITH THE HEALTH 2.0 CHAPTER OF BARCELONA
VENUE: PASSEIG DE MANUEL GIRONA, 29

FRIDAY 7TH FEBRUARY

08:30-14:00  PRECONFERENCE WORKSHOP: #DESIGNTHINKING FOR HEALTHCARE
ROOM: SALA PANORÁMICA
Please note: separate registration is required and limited places are available. For more information click here.

14:00-14:30  REGISTRATION

14:30-15:00  OPENING
PLENARY  ROOM: SALÓN DE ACTOS
15:00-16:15 PARALLEL SESSION 1

**PANEL**
ROOM: SALÓN DE ACTOS
Health and Economic crisis
HELENA LEGIDO-QUIGLEY (UK), SERGIO MINUÉ (ES)

**MENTORING SESSION: ONE-SLIDE / FIVE-MINUTE ORAL PRESENTATIONS**
ROOM: SALA PANORÁMICA
Moderated by XAVIER COS (ES), TOBIAS FREUND (DE)

16:15-17:30 PARALLEL SESSION 2

**THEME: MENTAL HEALTH**
ROOM: SALÓN DE ACTOS
A Collaborative Care Model to Improve Depression Management In Primary Care: The Indi Project
ENRIC ARAGONÉS (ES), JUAN A LÓPEZ-RODRÍGUEZ (ES)

**WORLD CAFÉ: GLOBAL HEALTH**
ROOM: SALA PANORÁMICA
PER KALLESTRUP (DK), LUISA PETTIGREW (UK), LAMINU KAUMI (ES)

**THEME: SKILLS 1**
ROOM: SALA VIDRIERA
2 in 1: Using Problem Based Interviewing to Give Feedback in Communicational Skills and Teaching How to Do It
SONIA CIBRIÁN (ES), MANUEL CAMPÍÑEZ (ES)

17:30-18:00 #DESIGNTHINKING FOR HEALTHCARE
ROOM: SALÓN DE ACTOS
Presentation of the solutions developed in the Preconference Workshop

19:00-20:30 OPENING CEREMONY WITH SEMFYC
THE CEREMONY WILL BE HELD AT HOTEL ALIMARA (BERRUGUETE, 126).
A SATELLITE BUS SERVICE WILL BE PROVIDED.
We Are Not One: How Inequalities in Europe Afflict Healthcare, Patients and Healthcare Professionals
Featured Speech by AMANDA HOWE (UK)

22:00 SOCIAL EVENT: LA FIRA PARTY
Free access for Forum Participants, ask at Registration Desk for free ticket

SATURDAY 8TH FEBRUARY

08:30-09:00 REGISTRATION

09:00-10:30 MAIN STAGE: FEATURED SPEECHES
ROOM: SALÓN DE ACTOS
One Vision: How Can We Unite the European Family Medicine
09:00-09:15 LUISA PETTIGREW (UK)
09:15-09:30 JOB METSEMAKERS (NL)
09:30-09:45 PER KALLESTRUP (DK)
09:45-10:30 A conversation with our three featured speakers, moderated by PETER A SLOANE (IE)
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<td>10:30-11:00</td>
<td>COFFEE BREAK</td>
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| 11:00-12:30  | **THEME: SHIFTING PERSPECTIVES: PUTTING THE PATIENT AT THE CENTRE OF HEALTHCARE**  
ROOM: SALÓN DE ACTOS  
e-Patients and GPs, a Joint Venture  
LORRAINE CLEAVER (UK)  

Harnessing the e-Patient's Power  
JOANNA LANE (UK)  

When a Doctor Becomes a Patient  
ODILE FERNÁNDEZ (ES)  

How e-Patients Are Leading the Way in Healthcare  
MARIE ENNIS O’CONNOR (IE)  

From "Helping a Person" to "Treating a Patient" - How We Lose Patient-Centeredness During Medical Training and How We Get It Back  
SEBASTIAN HUTER (AT)  

Patient Empowerment - From Pedagogy to General Practice  
ERNESTO MOLA (IT)  

**THEME: ALTERNATIVE MEDICINE**  
ROOM: SALA PANORÁMICA  
MARTIN SATTLER (LU), MARTIN SEIFERT (CZ)  

**THEME: SKILLS 2**  
ROOM: SALA VIDRIERA  
How to Identify and Manage Intimate Partner Violence Cases  
AURORA ROVIRA FONTANALS (ES), TANJA PEKEZ-PAVLISKO (HR), RAQUEL GOMEZ-BRAVO (ES)  

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<th>Time</th>
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| 12:30-13:30  | **PANEL: DISRUPTIVE INNOVATION – HOW TECHNOLOGY CAN HELP REINVENT HEALTHCARE**  
ROOM: SALÓN DE ACTOS  
Innovation: Connecting the Dots  
ÁNGEL GONZÁLEZ (ES)  

Mobile Health (In Cooperation with the Health 2.0 Chapter of Barcelona)  
JORDI SERRANO PONS (ES)  

The Healthcare Practice and Dr Google?  
FRANCISCO LUPIÁNÉZ-VILLANUEVA (ES)  

E-Learning  
NIKOS PAPACHRISTOU (GR)  

Take Care of Your Digital Identity  
FREDERIC LLORDACHS (ES)  

**PANEL: EMERGENCIES & OUT-OF-HOUR SERVICE: WHAT IS THE ROLE OF GPS IN EUROPE?**  
ROOM: SALA PANORÁMICA  
OLEG KRAVTCHENKO (NO), TANJA PEKEZ-PAVLISKO (HR)  

**PANEL**  
ROOM: SALA VIDRIERA  
Nutrition & Cancer  
ODILE FERNÁNDEZ (ES)  

The Role of Meat in Human Nutrition and How Genetic Breed and Animal Nutrition Affect the End Product  
MARCO NOVENTA (IT)  

**PANEL**  
ROOM: SALA VIDRIERA  
Nutrition & Cancer  
ODILE FERNÁNDEZ (ES)  

The Role of Meat in Human Nutrition and How Genetic Breed and Animal Nutrition Affect the End Product  
MARCO NOVENTA (IT)
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<td>14:30-15:30</td>
<td>PARALLEL POSTER SESSIONS</td>
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<td>Coordinated by ZUZANA VANĚČKOVÁ ŠVADLENKOVÁ (CZ), SUSANNE CORDING (CH), CHRISTINA SVANHOLM (DK), TOBIAS FREUND (DE), OLIVER VAN HECKE (UK), EVANGELOS FRAGKOULIS (GR)</td>
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<td>WORKSHOP IN COOPERATION WITH THE INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS (IFMSA)</td>
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<td>ROOM: SALA PANORÁMICA</td>
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<td>Medical Students in Primary Health Care - Opportunities and Prospects</td>
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<td>SEBASTIAN HUTER (AT), AGOSTINHO SOUSA (PT)</td>
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<td>15:30-16:00</td>
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<td>16:00-17:30</td>
<td>PARALLEL SESSION 6</td>
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<td>PANEL: TOO MUCH MEDICINE</td>
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<td>ROOM: SALÓN DE ACTOS</td>
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<td>Less Is More</td>
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<td>JUAN GÉRVAS (ES), MERCEDES PÉREZ FERNÁNDEZ (ES)</td>
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<td>Students and Medicalization</td>
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<td>BERTA GARCÍA (ES)</td>
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<td>THEME: SKILLS 3</td>
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<td>ROOM: SALA PANORÁMICA</td>
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<td>We Are on Duty (Coronary Acute Syndrome and Stroke)</td>
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<td>ALBA RIESGO GARCÍA (ES), MAGDALENA CANALS (ES)</td>
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<td>THEME: COMMUNITY ORIENTATED PHC</td>
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<td>ROOM: SALA VIDRIERA</td>
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<td>With the Community, Against the Grain: Experiences of Community Health in Spain</td>
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<td>FREDERICK MILLER (ES), ANGELINA GONZÁLEZ VIANA (ES), MARTA SASTRE (ES)</td>
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<td>17:30-18:00</td>
<td>CLOSING REMARKS</td>
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<td>18:00-19:00</td>
<td>DANCE &amp; SALSA WORKSHOP</td>
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<td>ROOM: SALA PANORÁMICA</td>
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<td>VERONICA PARENT (ES)</td>
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<td>21:00</td>
<td>SOCIAL EVENT: ATLANTIC BARCELONA DINNER &amp; PARTY</td>
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<td>Tickets can be purchased at Registration Desk (38 euros). Transportation included.</td>
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SOCIAL EVENTS

After each full day of science and medicine, we prepared two special Social Events for the participants to the 1st #VdGMForum!

**On Friday, February 7th,** everyone is invited to *La Fira*, a unique club with a circus museum theme, decorated with giant mirrors, carousel seats, statues and carnaval posters! Free entry! Forum participants will benefit from a special discounted price for drinks - ask at Registration for your free ticket to get the special price.

**On Saturday, February 8th,** finish the Forum in style at the spectacular *Atlantic Barcelona*, where you will enjoy a beautiful panoramic view of the city from the restaurant's terrace. Later in the night, join the party in the club of Atlantic, to catch the sunrise in the early hours of the morning! Forum participants can enjoy this event from 21:00 by purchasing a ticket for a fee of 38 euros which includes:
- special dinner in Atlantic Restaurant ([menu](#)),
- drinks,
- transportation by bus to and from Atlantic Barcelona ([map](#))
- the party in Atlantic Club

Tickets will be available on Friday and Saturday at the Registration desk.

Please note that access to the party in Atlantic Club on Saturday is free after 23:00 for all Forum participants. Transportation is included only for those with a ticket.
SCIENTIFIC COMMITTEE

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Raquel Gomez-Bravo - Chair
Tobias Freund - Chair
Per Kallestrup
Luisa Pettigrew
Persijn Honkoop
Zuzana Vanekova
Sara Rigon
Catarina Matias
Virginia Hernandez Santiago

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José Miguel Bueno
Athanasiou Symeonidis
Erik Teunissen
Jelle Stoffers
Jordi Serrano Pons
BARCELONA 1ST VDGM FORUM MAP

GOOGLE MAP: https://mapsengine.google.com/map/viewer?mid=zAdvnF2dn9Gw.ke8Ptl4FqcLA
A QUICK ‘N’ DIRTY GUIDE TO USING TWITTER DURING THE 1ST #VDGMFORUM

Twitter is an easy and fun way to comment during the #VdGMForum! You will be able to make observations and give feedback on presentations in real time or suggest a workshop to your friends and colleagues and much more!

In this social network, users post 140-character updates of what is going on in their lives along with links to things they consider to be interesting or useful to their followers. People use Twitter in many ways; some as a newsfeed by following prominent people or networks, some as a pseudo-chatroom and some as a microblog for updating people about the work they are doing and their personal lives.

First register!
To create an account just head to www.twitter.com and register with your email address; the procedure will require 5 minutes barely.

And then tweet!
You can post tweets easily using your browser of your computer, mobile phone and tablet. You can also use dedicated applications, which enrich the experience, such as TweetDeck or Metrotwit. There is even a wide range of applications on all mobile phones (iPhones, Androids, Blackberrys and Windows Phones included, such as the official app of Twitter, Tweetbot, and the visually beautiful Flipboard). Nowadays, most of the smartphones and tablets include some sort of integration as well.

So log in and start tweeting!

Channel your tweets!
But wait, how are others going to know that I’m talking about the VdGM Forum? It’s actually very simple and involves only the use of a special label: the hashtag. By using it, you can label tweets so that other users can see tweets on the same topic. Hashtags contain no spaces or punctuation and begin with the “#” symbol. Many times at events like conferences or concerts, the organizers will tell attendees to add a particular hash tag to their tweets to gather opinions about the event and unite people at the same event.

So there’s the fun part: you can post your own comments on the VdGM Forum placing our special hashtag after each message: #vdgmforum
Now other people will know that your message is about the #VdGMForum.

In fact, the hashtag has automatically been converted into a link and clicking on it will take you to a page with all the tweets tagged with this label from all users (i.e. not only from those you follow).

Do you prefer a better way to track and monitor all #VdGMForum tweets?

Just go to Tweetchat (http://tweetchat.com/room/vdgmforum), Twubs (http://twubs.com/vdgmforum), or oneQube (a guide can be found here by Marie Ennis O’Connor).

That’s it! Don’t forget you can tweet anything notable, your own ideas, opinions and point of views regarding the conference.

Your participation will be really important!

Vasco da Gama Movement’s official account is @VdGMeu. Just click on the ‘Follow’ button to add it among the people you follow: this way, any updates posted will be shown on your stream.

As a final remark, remember what Howard J. Luks said on Social Media being centrifugal, not centripetal: “Our actions, or endeavors, are centrifugal in nature. Our efforts extend from the center, which is us, and are meant for a global audience thirsty for healthcare knowledge, to learn from our experience, and to have a better understanding of their healthcare related issue.”

Geeky Tip
Head to Symplur.com to monitor the activity of our hashtag: http://www.symplur.com/healthcare-hashtags/vdgmforum/

References
DETAILED PROGRAMME

THURSDAY 6TH FEBRUARY

19:00-21:00  PRECONFERENCE SATELLITE MEETUP WITH THE HEALTH 2.0 CHAPTER OF BARCELONA
VENUE: PASSEIG DE MANUEL GIRONA, 29

Are you a technology enthusiast? Do you believe in the potential of technology that will lead to the Creative Destruction of Medicine? We are delighted to invite you to the Preconference Satellite Meetup with the Health 2.0 Barcelona!

Health2.0Bcn is an interdisciplinary group where professionals of the health sector join technology lovers with the aim to improve healthcare through the use of new technologies. Health2.0 wants to encourage projects related to health, developed by startups or individuals, offering them visibility, while inspiring others.

We would like to thank the organizers Aline Noizet, Frederic Llordachs, Jordi Serrano Pons and Sophie Park for their enthusiastic support and for making this meeting happen!

FRIDAY 7TH FEBRUARY

08:30-14:00  PRECONFERENCE WORKSHOP: #DESIGNTHINKING FOR HEALTHCARE
ROOM: SALA PANORAMICA

Design Thinking is about believing we can make a difference, and having an intentional process in order to get to new, relevant solutions that create positive impact.

- **It’s human-centred:** it begins from deep empathy and understanding of needs and motivations of people
- **It’s collaborative:** several great minds are always stronger when solving a challenge than just one.
- **It’s optimistic:** Design Thinking is the fundamental belief that we all can create change.
- **It’s experimental:** it gives you permission to fail and to learn from your mistakes, because you come up with new ideas, get feedback on them, then iterate.

It has five phases that help navigate the development from identifying a design challenge to finding and building a solution. The Vasco da Gama Movement is developing a fantastic workshop that will enable you to learn firsthand how Design Thinking can be used to innovate in health and healthcare. During this workshop, teams will work together to explore and create solutions to real healthcare challenges.

The participants will work on problems identified and will use the Design Thinking methods to gain a deep understanding of the problem and develop innovative ‘human-centred’ solutions (i.e. solutions that truly meet the needs of users). These will be presented during the Plenary Session on Friday, 7th February, at 17:30. Methods will include user-interviews, observation, brainstorming and rapid prototyping, with the aim of creating solutions that combine human desirability and usability with business viability and technological feasibility.
FRIDAY 7TH FEBRUARY

14:00-14:30 REGISTRATION

There are two types of registrations available:

- **General Practitioner / Family Doctor (Trainee, first 5 years, senior)** - The registration fee is **100 Euros**
- **Patients and undergraduate medical students** - The registration fee is **50 euros**.

Please go to the Registration Desk for more details. Next to it is the Memorabilia Desk where you can find t-shirts, umbrellas, mugs, badges and pens with the VdGM and Forum logo.

Let your friends know you’re attending the Forum by joining the Facebook event: [www.facebook.com/events/119640248206586](http://www.facebook.com/events/119640248206586) and tweeting using the #VdGMForum hashtag.

14:30-15:00 OPENING

PLENARY ROOM: SALÓN DE ACTOS

15:00-15:15 PANEL

PARALLEL SESSION 1

ROOM: SALÓN DE ACTOS

Health and Economic crisis

HELENA LEGIDO-QUIGLEY (UK), SERGIO MINUÉ (ES)

MENTORING SESSION: ONE-SLIDE / FIVE-MINUTE ORAL PRESENTATIONS

ROOM: SALA PANORÁMICA

Moderated by XAVIER COS (ES), TOBIAS FREUND (DE)

Helena Legido-Quigley is a Lecturer in Global Health at the London School of Hygiene & Tropical Medicine. She has conducted research on European health policy, quality of health care, health systems, chronic conditions, and migrant populations. Her latest research focuses on the impact of the financial crisis and austerity measures on health. Her work has been published in peer reviewed journals such as the Lancet, British Medical Journal and PLOS Medicine. It has also been widely covered in International media including the Economist, the Financial Times and Huffington Post.

Sergio Minué is a specialist in Family and Community Medicine and professor of Health Policy and Ethics Department in the Andalusian School of Public Health. At this moment he is Director of Innovation and Research in this institution. He is leading some research project related to clinical decision making in primary care, about diagnostic error, and he is working in some international projects about the impact of the economic crisis in health systems. Sergio carries out functions as semFYC representative in WONCA/CIMF. Member of the semFYC group in patient safety, he publishes two blogs (“El gerente de Mediado” and “La cara Ve”). @sminue | [http://gerentedemediado.blogspot.com.es/](http://gerentedemediado.blogspot.com.es/)

Go to the Oral Presentations abstracts
Depression is one of the most important mental disorders and constitutes a public health problem of the first order. By its position in the health system and its accessibility, primary care has a central role in addressing depression and the depressed patients are treated mainly on this level of care. However, there are significant shortcomings in the diagnosis, management and health outcomes in these patients. Previous studies in the U.S. have shown promising results in the treatment of depressive disorder in primary care based on a structured approach, derived from the management of chronic diseases model. Our research group has developed a model to improve the management of depression in primary care with measures applicable in the Spanish health system, and we evaluated this intervention through a randomized controlled trial. The results have verified the hypothesis that the implementation of the INDI programme leads to better outcomes in the management of depression in primary care with respect to the usual care.

The Indi program for depression management:
It is a multi component structured program for care of depression based on the model of care for chronic diseases. It includes clinical and organizational measures and training. It is designed considering its feasibility and the various components incorporated are according to current conditions in the Spanish health system. Particularly new is the empowerment of nursing care for depression. The programme includes structured training for professionals and the availability of clinical guidelines and treatment algorithms based on scientific evidence. Incorporates and promotes the role of the nurse in the care of depression: research on patient needs, design plans of care, psycho-education, promoting adherence to treatment and active and systematic clinical monitoring of patients in collaboration with the physician. With the psychiatric level optimal liaison and support mechanisms were established.

Come join us for a world café on global health! This session offers a special opportunity for you to meet, explore, discuss and debate with participants the subject of global health. Not sure what global health means or what a world café is? Come and find out! We will explore subjects such as the global burden of disease; health systems; global health governance; social, economic and environmental determinants of health; cultural diversity and health; human rights and ethics. There will be no café con leche, but there will be some very good global music!
We will describe and teach the Problem Based Interviewing (PBI) methodology, that we have widely used for a long time to give feedback to health professionals by analyzing a videotape of a clinical interaction. In this session, a colleague brings to a small group of other professionals a videotape recording of a consultation. We start by remembering the rules of participation (we'll talk about communication facts only - unless the colleague wants to receive feedback about a clinical issue -, in a constructive manner, and with the control of a moderator who conducts the interventions so that they become useful). Then the person who brings the tape explains his agenda (he/she asks the group for help in a specific task or with a specific problem he/she has had in the consultation), and the group helps to establish it. We go through the watching of the tape and stop it whenever a person in the group wants to point at something that has just happened, giving the option first to talk to the person who brings the tape and helping him/her all the way. Finally, the conductor makes a summary of the things we have learned in the process.

As we may find people who have never heard of the PBI methodology along together with people who may experienced in PBI and want to learn how to conduct a group, we want to offer the possibility of learning "how it works" and "how to teach it" both. To do so, we will follow the same structure as if we were in an usual PBI session, but when the teacher sees a learning topic he will stop the session with a specifically taught signal (like putting on and taking off a hat) and tell the group what has been going on in the group and why has the conductor acted as he has, what has he been asking and why, how can it help in the process of learning, maybe offering a "theory pill", et cetera, so that the group can find out why the conductor acts as he acts and what his teaching purpose is.

The learners should have the possibility to "live" a PBI session and learn communicational skills while giving feedback to a colleague. On the other hand, they should learn how to conduct a group so that they can reproduce the process of a PBI session in their own settings.

Prof Amanda Howe was elected as WONCA President-Elect in Prague in June 2013. She will become the first woman to be WONCA President in 2016. She was elected RCGP Honorary Secretary in 2009. Prof Howe practices at the Bowthorpe Medical Centre in Norwich, England and has been Professor of Primary Care at the University of East Anglia since 2001. She has been deeply involved with WONCA since 2000, when she facilitated a workshop for their Working Party on Women and Family Medicine. She is on their Executive, chaired the group from 2007-2009, and hosted an international meeting at UEA in 2009. Prof Howe now serves on the newly created Equity Committee, is a member of WONCA Europe's Bylaws Committee, and (also as part of her role as RCGP Honorary Secretary), often attends WONCA conferences in Europe and around the world to contribute relevant papers and promote the development of family medicine.
### SATURDAY 8TH FEBRUARY

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<td>09:00-10:30</td>
<td><strong>MAIN STAGE: FEATURED SPEECHES</strong></td>
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<td><strong>ROOM: SALÓN DE ACTOS</strong></td>
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<td><strong>One Vision: How Can We Unite the European Family Medicine</strong></td>
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<td>09:00-09:15</td>
<td><strong>LUISA PETTIGREW (UK)</strong></td>
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<td>09:15-09:30</td>
<td><strong>JOB METSEMAKERS (NL)</strong></td>
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<td>09:30-09:45</td>
<td><strong>PER KALLESTRUP (DK)</strong></td>
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<td>09:45-10:30</td>
<td>A conversation with our three featured speakers, moderated by <strong>PETER A SLOANE (IE)</strong></td>
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**Dr Luisa Pettigrew** is a young family doctor in London. Whilst in VdGM (2008-2011) she coordinated the 'Hippokrates' international exchange programme, helping secure its first European Union funding grant. In parallel in the UK she helped establish the Royal College of General Practitioners' Junior International Committee to enable the future generation of family doctors in the UK to also further in international activities. In 2013 she was elected as a member at large to WONCA's executive board. Luisa has undertaken a Diploma in International Health (2003) and Master in Health Policy (2011). When possible Luisa has taken time to undertake voluntary work for various NGOs and health organisations in Argentina, Nicaragua, Costa Rica, Ecuador, Mexico and Mozambique. In addition she has undertaken work for the World Health Organization and Johns Hopkins School of Public Health.

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The introductory interview to the topic is available here:
[http://vdqm.woncaeurope.org/forum/hangout](http://vdqm.woncaeurope.org/forum/hangout)

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**Prof Job Metsemakers** became in 2002 professor and chair of the Department of Family Medicine, at Maastricht University. At the international level, he has been active as consultant in health care reform in Eastern European countries, and in development of family medicine in Indonesia. He has been on the executive board of The European Academy of Teachers in General Practice and Family Medicine (EURACT), and currently is on the Advisory Board of the European General Practice Research Network (EGPRN). For the last six years (until June 2013) he was the Honorary Secretary of WONCA Europe. From 2010-2013 he served on the WONCA membership committee. He succeeded Tony Mathie (UK), in June 2013, to become President of WONCA Europe 2013-2016.
e-Patients and GPs, a Joint Venture

**LORRAINE CLEAVER (UK)**

As a patient with two chronic conditions, I have discovered first hand the benefits and limitations of the internet in managing my health. There is great knowledge to be discovered but great harms can lurk there too for the unwary. Understandably, doctors, and perhaps especially GPs, can be mistrustful of the breadth of knowledge patients bring to their consultations. But working together in a more meaningful way has helped many of us patients and GPs to better outcomes. It has thrown up issues both parties have had with, for example, guidelines, blood tests and the patients own participation in their care. I would like to talk about how my GP and I overcame these issues and successfully managed these complex conditions, reducing medications and illness in the process whilst participating fully as an e-patient.

Harnessing the e-Patient's Power

**JOANNA LANE (UK)**

After our son's suicide five years ago I began a campaign to raise awareness of an under-diagnosed but common effect brain injury. The work I have done would not have been possible without the internet, and in my presentation I narrate my own experience of the remarkable power that easy access to medical information gives the lay person, and the mistakes I made as I learned to use it. I believe there is an urgent need for GPs to provide guidance to patients and families on how to channel the latter's intense, often desperate motivation productively and how to focus their efforts in such a way as to help rather than hinder the work of the medical profession. I offer some possible ideas and hope that other suggestions will emerge in discussion.

When a Doctor Becomes a Patient

**ODILE FERNÁNDEZ (ES)**

I am a Spanish Family Physician. In 2010 I was diagnosed a Stage 4 ovarian cancer. Apart from chemotherapy, I also changed my diet and turned to some natural therapies, such as reiki, meditation, visualization and yoga. Which role did the healthcare system play in this process? I received chemotherapy and had my ovarian tumor removed, but they did not help in any other way. When I was nearly dead with fright, I was not comforted or supported by conventional medicine. When I asked if there was something else I could do apart from following the official treatment, I was told I could only wait. Family Physician should offer a personalized attention to patients and keep very close to them all the time. The patients should feel all the healthcare staff support. Family doctors can play a very important role in this respect. We have the chance of acting as the support the cancer patients need. Let's have a chat with them, let them tell us about their doubts and fears, make us questions and inquiries.

How e-Patients Are Leading the Way in Healthcare

**MARIE ENNIS O'CONNOR (IE)**
From "Helping a Person" to "Treating a Patient" - How We Lose Patient-Centeredness During Medical Training and How We Get It Back

SEBASTIAN HUTER (AT)

As for many other students, one key motivation for me to start studying medicine was the "wish to help people". Most of us haven't heard about "patient centered care" when we start studying, yet naturally the people were in the center of our motivation. There are many reasons why we medical students can slowly lose this ideal along the way and replace it with pragmatism. Medical school is not only were we acquire our medical knowledge, but also were we learn to "be a doctor" and act like one. What happens in this process? What does it mean for the doctor-patient relationship? How can we get through it without losing our idealism? And if we lose it, how can we get it back?

Patient Empowerment - From Pedagogy to General Practice

ERNESTO MOLA (IT)

Efforts to improve the quality of healthcare for patients with chronic conditions have resulted in growing evidence supporting the inclusion of patient empowerment as a key ingredient of care. An additional characteristic for the European definition of general practice / family medicine concerning patient empowerment has been approved in 2011 by the European Council of WONCA Europe. The aim of the presentation is to illustrate the meaning of the term “empowerment”, as defined by literature, and the reasons why the European definitions of general practice/family medicine contain patient empowerment as a characteristic of the discipline.

Alternative Medicine in Family Medicine and General Practice

MARTIN SEIFERT (CZ)

Complementary and alternative medicine (CAM) is often what your patients do to relieve their symptoms before consulting the doctor - or when evidence-based methods don’t show satisfying effect - often in parallel to conventional medical treatment. Some patients prefer to discuss their trials and experiments with you as their doctor, while others do not. If your patients find out that you are unfamiliar with the alternatives, or if you condemn alternative treatments without knowing anything about them, you risk losing their trust in you as a guide through their health. The popularity of different alternative medicinal methods varies from country to country, among patients as well as doctors.

The aim of our interactive workshop is to share and compare internationally the experience with CAM and to learn about attitudes of GPs in different countries. Moderators will give a basic overview on CAM and will try to acquaint you with a number of non-conventional medicinal methods with an emphasis on traditional Chinese and Indian medicine. A practical demonstration will be included. We’ll find out together whether we share a common view of some controversial topics. We will search for positive and negative aspects of CAM from patient and GP perspective.

We hope that you choose to join us in our workshop. If you do so, please spend some time beforehand thinking about alternative medicine at your practice and in your country. Try to learn some facts. We are looking forward to seeing you in Barcelona!

The NADA Protocol

MARTIN SATTLER (LU)

History: In the mid-1970s, Michael Smith, a medical doctor at Lincoln Hospital in the South Bronx area of New York, modified an existing system of auricular acupuncture into a simple technique for the treatment of many common drug addictions as an alternative to methadone. This selection of ear points proved to be extremely effective in the treatment of addictions, and became what is now referred to as the “NADA protocol.”

NADA protocol in GP practice: Martin Sattler is a GP working as a partner in a GP practice in Luxemburg since 2010 and using the NADA protocol regularly in the practice also for psychological disorders like depressions, post traumatic syndrome with very good results. The simple and cost-effective use is making this treatment accessible in any GP practice.
Domestic Violence is a significant public health problem, statistics on its prevalence indicate that it is a worldwide epidemic. Are we really aware of it as health care professionals?

The last report of WHO (World Health Organization) this year: “Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence,” found that intimate partner violence affects 30% of women worldwide and is the most prevalent type of violence against women, 38% of all women murdered are killed by their intimate partner and 42% of women who had been sexually or physically abused by their partner were injured. But it is estimated that only 3% of cases are presently being identified in primary care settings, and general practitioners (GPs) are uncertain of what to do if a case is discovered.

GPs are the most likely first-line professionals to be contacted but low awareness amongst them concerning intimate partner violence (IPV) has been demonstrated repeatedly, and there is unanimity in calls for effective trainings of primary care physicians!

How to deal with women which doesn't or can't leave violence relationship? What to do in the situation when women insist to don't call police, but we are obligatory by low? Do we have good coordination with social welfare? How to detect and how to approach it in your practice? What will you do in a case of long-lasting psychological abuse? What are consequences for our mental health?

We will split in groups to work on these questions and after discussing and analyzing in groups, we will offer the participants of the workshop evidence-based guidance on appropriate care and improve their approach.

Innovation: Connecting the Dots
ÁNGEL GONZÁLEZ (ES)

In the new Collaborative Economy we all are entering due to the power of the Social Web it is said that innovation, rather than being a solo one shot aha moment, is a never ending process of connecting dots.

Those dots can come from unexpected ideas, thoughts, individuals, at glance perceptions, etc. Sometimes the dots are just over there; many times are hidden in plain sight. During the innovation process you have to hardly believe that, at some point, all those apparently
unrelated dots will start to connect and bring into life to a unique concept: a new category of a disruptive product or service challenging the establishment and status quo. As the Austrian surgeon and economist J. Schumpeter stated on his theory of creative destruction: only those who innovate will survive (...). Now more than ever is time to foster innovation, to rethink and reinvent if we want to survive in this tough but exciting systemic and identity crisis. Seems that everything is converging and boundaries between traditional disciplines are being diluted, mashed up or even disappeared. It is time to find inspiration across other industries by making connections outside your field of expertise, attending conferences that you normally would not attend, travelling more often and learning from other cultures. Venture outside your comfort zone and do not be afraid of potential setbacks or failures because they are part of this journey. And most importantly: make the most of the social web. It will empower you to find, connect, relate, learn, share, acknowledge and be considered in a new horizontal scenario with no hierarchy but the one of the wisdom of the crowds.

Mobile Health (In Cooperation with the Health 2.0 Chapter of Barcelona)
JORDI SERRANO PONS (ES)
Jordi is a General Practitioner and the founder of the UniversalDoctor Project, the main objective of which is to improve multilingual communication between health professionals and patients. He is co-founder of Zero Mothers Die, a Global partnership Project using mobile health to improve maternal health. He recently started working as a consultant to the WHO and TicSalut Foundation and collaborates very frequently with the Geneva Health Forum as advisor on Innovation and Health cited Forum (Forum of Global Health).

E-Learning
NIKOS PAPACHRISTOU (GR)
What is the current landscape in medical education? What are the global demands for academic training and continuous professional training? We will on a era where eLearning does not provide support for learning only. Massively distributed content, international initiatives on higher education, old technologies used more efficiently combined with new emerging ones have started to transform the business model of education as well. The mashup of eLearning technology along with frugal innovation in the developing countries set a scene where formal learning and education can truly be tailored to person’s needs, available on demand and ubiquitous. What is most important eLearning has the potential not only to support the workforce capacity and lifelong competency building globally, but nurture a new, dynamic relationship between the patient, the general doctor and the rest of the cure network also.

The Healthcare Practice and Dr Google ?
FRANCISCO LUPIÁÑEZ-VILLANUEVA (ES)
Internet is part of our everyday life, directly or indirectly. The healthcare practice can't remain in margin of this reality and it's necessary to understand how this technology fits within the medical consultations and the interaction with the patients.

Take Care of Your Digital Identity
FREDERIC LLORDACHS I MARQUES (ES)
Choosing a healthcare professional has turned to be a social phenomenon, whose favorite playground is the Internet. Being present on the Web is a must for doctors who want to be more visible and get new patients. But there are some guidelines to follow to make it effective.

12:30-13:30 PARALLEL SESSION 4
PANEL: DISRUPTIVE INNOVATION – HOW TECHNOLOGY CAN HELP REINVENT HEALTHCARE
ROOM: SALÓN DE ACTOS
PANEL: EMERGENCIES & OUT-OF-HOUR SERVICE: WHAT IS THE ROLE OF GPS IN EUROPE?
ROOM: SALA PANORÁMICA
OLEG KRAVTCHENKO (NO), TANJA PEKEZ-PAVLISCO (HR)
PANEL ROOM: SALA VIDRIERA

Evaluation and country-to-country comparison of the role of out-of-hours and emergency care in different European locations as part of the educational strategy and workforce retention. The main question is whether there are significant differences in organizing and conducting out-of-hours/on-calls and emergency care practices in different European locations. The earlier data suggested that there were certain differences in the organization and practical application of such activities from country to country in Europe.
After the overview of the theoretical background the participants will be divided into 2-3 different groups to discuss the above mentioned data, to share their personal experiences and understanding of the topic and to develop the mutual European strategy for the state-of-the-art performance during out-of-hours and emergency care in different European locations.

There are planned some hands-on activities re. emergency skills essential for medical practitioners. Both experience and literature surveys intend to recognize the out-of-hours and emergency care as a critical point in everyday medical practice of GPs and in hospitals. It also seems to be one of the most vulnerable areas both for a medical practitioner and his/her patients.

The sharing of the expertise from different parts of Europe would be essential to create a mutual program which could be later utilized in any postgraduate educational system across Europe. The creating of practice proved standards in out-of-hours and emergency care also could play an important role in recruiting and retaining of the workforce.

**12:30-13:30**

**PARALLEL SESSION 4**

**PANEL: DISRUPTIVE INNOVATION – HOW TECHNOLOGY CAN HELP REINVENT HEALTHCARE**

**ROOM: SALÓN DE ACTOS**

**PANEL: EMERGENCIES & OUT-OF-HOUR SERVICE: WHAT IS THE ROLE OF GPS IN EUROPE?**

**ROOM: SALA PANORÁMICA**

**13:30-14:30**

**LUNCH**

**Nutrition & Cancer**

**ODILE FERNÁNDEZ (ES)**

Cancer is a disease associated with our diet and lifestyle. 1 out of 3 cancers could be prevented with an optimal diet; if, on top of that, we led a healthy lifestyle, 2 out of 3 cancers could also be prevented according to the International Agency for Research on Cancer. 1 out of 3 men and 1 out of 4 women will suffer cancer. In 2012, nearly 14 million new cases were diagnosed, and 8 million people died because of cancer.

A diet based on fast food, sugary and refined foods, trans and saturated fats and processed foods with plenty of additives and pesticides is related to a higher cancer rate. However, a semi-vegetarian diet based on vegetables and fresh fruit prepared with mild cooking techniques has proven to be effective for cancer prevention.

We, as family doctors, can play a very important role in cancer prevention. We can advise our patients and help them change their lifestyles. In order to be efficient advisors, doctors must have an optimal training based on truthful, scientific and corroborated evidence.

**The Role of Meat in Human Nutrition and How Genetic Breed and Animal Nutrition Affect the End Product**

**MARCO NOVENTA (IT)**

Red meat contains high biological value protein and important micronutrients, all of which are essential for good health throughout life. Most healthy balanced diets will include lean meat in moderate amounts, together with starchy carbohydrates (including wholegrain foods), plenty of fruit and vegetables and moderate amounts of milk and dairy foods. Within the context of a healthy, varied diet lean red meat contributes protein, long chain n-3 fatty acids, and micronutrients such as iron, zinc, selenium, vitamin D, vitamins B6 and vitamin B12. Some of these nutrients are more bio-available in meat than alternative food sources, and some have been identified by SACN as being in short supply in the diets of some sections of the population like in vegetarians. Through animal feed, you can modify and improve the quality of the end product. In steers and in heifers, medium-high nutrient levels reduce the production cycle by improving tenderness and color of the meat; slaughtering early promotes optimum color and a reduced amount of collagen. Raw materials like linseed brings to the rumen high level of CLA (conjugated linolenic acid) which have anticarcinogenic and antiatherogenic properties plus are modulator of the immune response (McAfee et al., 2010 Meat Science, 84:1-13). The European Community bans the use of hormones in cattle but in the United States and Canada is allowed to use.
The posters will be displayed throughout the whole conference starting on Friday. On Saturday 8th February at 14:30, the posters will be presented and discussed in a dedicated session. In the 60-minute session we will be divided in 6 smaller groups (each one will have 5 posters). The posters will be discussed individually one at a time. Poster authors are invited to be present for this poster session. However, for the #VdGMForum we will follow the EGPRN model for the presentations of the posters: a third person (not the author) will present the poster. This person will be appointed by the facilitators. After the 3-minute presentation from this person, there will be a 2-minute reaction time from the author. In these two minutes the author can make any corrections and additions to the presentation of the colleague. After that, there will be a 5-minute question time, during which the audience can ask questions. The total time dedicated for each poster will be 10 minutes.

We’ve chosen this method of presentation because we believe it will increase the interaction and will help value the author’s work. At the end of the conference the best poster will be awarded with a prize.

**Go to the Poster abstracts**

Primary Health Care (PHC) has received increasing attention by global stakeholders and policy makers in order to make health care systems more efficient and to prepare for the 21st century challenges health care is facing. In order to achieve this shift towards more PHC, it has to be represented adequately in medical curricula. In this interactive workshops, done by medical students, we want to focus on how students can benefit from having primary health care in their training, how it can be integrated into the curriculum and how international exchange can be essential to get medical students enthusiastic about PHC.
Less Is More

JUAN GÉRVAS (ES), MERCEDES PÉREZ FERNÁNDEZ (ES)

Too much of a good thing is bad. Too much of a good thing may not be wonderful. Tetanus vaccination, every ten years or just a shot at 65? Densitometry, yes or no? Pre-surgery diagnosis test, how much if any? Annual health check-up, no one? Iodine supplement in pregnant women, always? Vitamin D for elderly, why and how much? Statins in primary prevention, needed? Too complex patients and polypharmacy or too simple health system? Cancer screening in the old? Monitoring performance for glucose in patients with diabetes type II? What is the right amount of Pap smear? Medical radiation with no limit? In general the motto should be: “maximum quality, less quantity”. In general, “less is more”. You can have too much of a good thing. The most obvious things are food and alcohol, an excess of either can make us fat or drunk. What about iron fortification?. We are sorcerer’s apprentices. Again, probably, too much of a good thing. Mothers who produced milk with less iron and infants who had decreased iron stores at the time of weaning may have been more likely to survive the transition to solid foods by having limited iron available for pathogens. Contemporary fortification practices may undermine these adaptive mechanisms and increase infant illness risk. As physicians we need to thing and re-exam our daily practice.

“When sick I want to be cared for by doctors who doubt every day the value and wisdom of what they do” [Richard Smith].

Students and Medicalization

BERTA GARCÍA (ES)

University is the starting point of all that we learn and practice in medicine. It should be a perfect balance between a scientific view, in which evidence is needed in order to support our ideas and practices; and a humanistic principle, in which we are aware of the fact we are treating another human being who deserves respect, and so ethics should be present in all our decisions. In order to reach this perfect balance several issues are decisive: What and how things are taught, the congruency between theory and practice, and a healthy skepticism regarding what we read. This is crucial as, once we finish university, we are alone in the process of filtering information and making decisions.

The pharmaceutical industry is frequently related, both in an indirect and direct way, to the information we receive. This might seem logical as it -as well as the technology industry-, provides the tools for our everyday practice and is virtually in charge of the continuing medical education. However, the information offered by the pharmaceutical industry is inevitably biased due to the conflict of interests. The direct contact with a wide range of health professionals throughout university is very educational in this sense, as students are able to see the different approaches in medicine. Malpractice is not always evident, and in fact most of the time it seems harmless. An example of this is the unnecessary use of diagnosis tests as a way of reassuring patients. Not only can this put the patients at risk but it is also unneeded, as what patients truly seek is information and attention towards their fears and doubts. Another example is what’s known as defensive medicine: the excessive use of diagnosis tests as a way of avoiding potential lawsuits. Overdiagnosis is another form of malpractice that is increasingly common.

Fortunately not all is bad news, as medicine students also experience good medical practice, like the rejection of prostatic cancer screenings, the encouragement of breastfeeding, and the education in the rational use of antibiotics. To promote this good clinical practice education schemes should be objective, critical and independent from industrial (commercial) interests.

How common do you think medicalisation and overdiagnosis are? Do they benefit or damage the patients? And what about the healthcare system? What is the role of the pharmaceutical industry in this matter? What solutions can you think of that would guarantee an independent and high-quality education?
We are on duty at the health centre or at the hospital. Two of the most common situation that we will see is coronary acute syndrome and stroke. Coronary Acute Syndrome includes ST elevation myocardial infarction, non ST elevation myocardial infarction and unstable angina. In all cases we need to act quickly but each of these have a specific performance. In this session we’ll review the initial assessment and treatment of each both the hospital and in the outpatient scope. Around 15 million people worldwide suffer from stroke every year. Stroke is the first cause of death in women in Spain and the first cause of dependence in Europe. Stroke in a medical emergency and the evolution of the disease will depend in great manner of a good first medical attention. We will see in this session how we have to act in this emergency situation.

For many health practitioners, even if they appreciate the value of working with their local populations to address important social determinants of health in their communities, they often find that they are working at odds with many issues, from time constraints, to resistant administrators, to demands of individual patient care -- that they are working “against the grain”. In the session, we will present community health experiences in Spain at different levels, from the perspective of a center for health promotion, to an public agency for public health, to a description of networks of community health projects in Spain and how in each level these organizations support community work despite the many challenges. We will leave ample time for participants to share their experiences in community health in their settings and try to gather some conclusions about how progress can be made in this important aspect of our work.

Tickets can be purchased at Registration Desk (38 euros). Transportation included.
Praksis Plus – the process of devising an electronic handbook for newly qualified GP’s.
Ulrik Kirk, Eva Schandorf
The Danish College of General Practitioners, Dagmar Health Centre, Ringsted

Background
In The New GP’s Handbook by Davies et al. the process of going from being a GP trainee to a qualified GP with your own practice is described like “falling off a cliff”. We decided to explore whether newly qualified Danish GPs experienced this bewilderment, and afterwards we asked them to work out practical solutions to these basic questions. To make the data easy accessible an electronic handbook was edited and created, which hopefully can help the newly qualified GPs in their first 1-5 years in practice. The electronic handbook is available on the Danish College of General Practitioners’ homepage, www.dsam.dk.

Research question(s)
How to choose the right practice as a newly qualified GP, and what practical difficulties do you encounter in the first 1-5 years of your GP working life?

Methods
First 8 focus groups were held in four of the five Danish regions to emphasize the difficulties and challenges of the participants (GP trainees and nearly qualified GPs). All interviews were transcribed and cataloged, and on behalf of this data, 3 workshops were held. The participants were asked to work out solutions to these specific questions as well as comment on existing flow-charts from the Danish Medical Association.

Results
Many newly qualified GPs expressed a lack of knowledge regarding the practical aspects of management, business skills and leadership, and they expressed frustration about difficulties finding accessible answers. Despite the fact that more than 60 GP trainees and newly qualified GPs participated, not all aspects of a GP’s first years in their own practice were described.

Conclusion(s)
The project had a surprising motivational factor to the GP trainees and newly qualified GPs.

Points for discussion
1. Could the Danish electronic handbook be an inspiration for other European countries?
2. How to update and maintain the handbook?
3. How to enable newly qualified GPs for more practical tasks? Courses and/or network groups?
Introduction:
General Practice, known in some countries as Family Medicine, has become a specialty in its own right. WONCA Europe’s definition has become a reference point for specialty and training programs. This is a huge step forward for the discipline at the European level, and it constantly leads to proposals to reform training. However, in this context, we must not forget the Bologna Process; created with a goal to provide a common basis for the higher education. In this work, we investigate the state of standardization of training in General Practice in Europe.

Material and methods:
It was a comparative study of official programs in general medicine in nine European countries, chosen according to specific criteria. Each country has been described in five areas: access to training, length, rotations and places of rotations, classroom training, and evaluation.

Results:
We found a lot of diversity in the training programs between the nine European countries. Access to the program was most often done through a national standardized test. The length of the training varied between 3 and 5 years. We also found large differences in the models of the curriculum. Some programs had a common core (internal medicine, gynecology and/or pediatrics). The emergency training was mandatory in most countries. The compulsory rotation in General Practice took a very different length of the total training time depending on the country: 16% in France to 54% in Poland. There were also differences in the type of the rotations.

Conclusion:
For the standardization of higher education in Europe and to allow the free movement of doctors between the countries, it is important to study the progress of the specialty in different countries. To date, there are still large disparities in training in General Practice in Europe.
OP-003
Exploring the clustering of chronic pain, depression and heart disease in a general population-based cohort
Oliver van Hecke, Nicola Torrance, Blair. H. Smith, Generation Scotland
Chronic Pain Research Group, Population Health Sciences, Medical Research Institute, University of Dundee, United Kingdom

Background
Current research points towards a common link between chronic pain, depression and/or heart disease and subsequent poor health and premature death.

Methods
Data from Generation Scotland: the Scottish Family Health Study (chronic pain, cardiovascular and mental health parameters) was analysed using logistic regression modelling to calculate the likelihood of one, two or all three condition(s).

Results
24,042 participants were included. 7,162 (36%) reported any chronic pain of which 3,664 (22%) were classed as severe; 2,009 (10%) had significant exertional chest pain (Rose Angina); 2,771 (12%) had a history of major depressive disorder. Individuals with any chronic pain were significantly more likely to have depression and angina than those without chronic pain [adjusted OR 6.59, 95% CI 4.89-8.87]. This increased further with severe chronic pain [adjusted OR 9.35, 95% CI 6.82-12.82].

Conclusion
The results support current theory of an underlying shared-aetiology and/or genetic aetiology between these conditions.
Background
Mild cognitive impairment refers to a decline in cognition that does not interfere significantly with daily activities, and it has been proposed as an intermediate stage in the progression to dementia. Clinical studies have shown an association between a socially active lifestyle and a better cognitive performance, opening a new window for early intervention in the prevention of dementia, especially in the primary health care setting.

Objectives/aims
The goal of this study is to characterize the association between social interaction and mild cognitive impairment in an elderly population of the north of Portugal. One aim is to determine the prevalence of mild cognitive impairment in this population, and characterize its association with socio-demographic variables, personal background, functional independence and social interaction. This will help to elucidate areas of future therapeutic intervention.

Planned methods
An observational, cross-sectional and analytical study, with a descriptive component, will be held in three Family Health Care Units in the north of Portugal. These three units have distinct socio-demographic characteristics, ranging from rural to urban. After randomization, 299 users aged 65 or more will be contacted by phone and receive the Cognitive Test MoCA, as well as an evaluation questionnaire. As such, this study aims to understand if the level and quality of social interaction can influence the development of mild cognitive impairment in elderly individuals, taking into account multiple variables, through statistical analysis.
Adherence of Italian general practitioners to European guidelines for neuropathic pain: an observational study.
Domenico Italiano, Rosalba Nania, Veronica Giacchi, Santi Inferrera, Umberto Alecci.
Italian Society of General Practice (SIMG), Messina, Italy

Background:
Neuropathic pain (NP) is defined as pain arising as a direct consequence of a lesion or a disease affecting the somatosensory system. Examples include diabetic polyneuropathy, postherpetic and trigeminal neuralgias and painful radiculopathy. A fifth of adults in Europe have moderate or severe chronic pain, but only 2% are managed by a specialist. Indeed patients with NP often report their symptoms to their general practitioner (GP) where they are managed, but not necessarily referred to secondary care. Commonly prescribed treatments for NP include tricyclic antidepressants, the antiepileptics gabapentin and pregabalin, along with opioids, topical lidocaine and the antidepressants venlafaxine and duloxetine. To date treatment practice for NP continues to vary considerably in terms of starting treatment, achievement of therapeutic doses, and correct sequencing of therapeutic classes, thus leading in some cases to inadequate pain control. In 2010, the NICE (National Institute for Health and Clinical Excellence) has published a new clinical guideline on the pharmacological management of NP in non-specialist settings. However, very few studies have examined the extent to which treatment of patients with NP in the community is consistent with international guidelines.

Objectives:
We propose to perform an observational study to evaluate the GP management of a cohort of NP patients in Italy, in order to assess appropriateness and adherence to European clinical guidelines.

Planned Methods:
Italian GP registered to the Italian Society of General Practice will be invited to participate in the study. A sample of 50 GPs will be selected according professional profile and geographical criteria. Each participating GP will be requested to identify patients aged >18 years, consulting the GP for the management of painful diabetic neuropathy, post-herpetic neuralgia and oncologic NP. Ten eligible consecutive patients of each above-mentioned category will be enrolled into the study. Patients were not involved in data collection, but they were requested to give informed consent. A questionnaire including demographic and treatment data, with particular regard to therapeutic classes, dosage, timing and outcome of each step of therapy, will be filled by the GP. A descriptive statistical analysis will be provided to assess the adherence to the NICE guidelines.
Background
Aspirin's role in reducing risk of cardiovascular events is well established. Aspirin is also discussed having a favorable impact on cancer incidence, metastasis, and mortality as primary prevention, especially in colorectal cancer. The anticancer effect of aspirin includes induction of cell apoptosis as well as inhibition of cyclooxygenase-catalyzed prostaglandin production. In colorectal cancer, aspirin may also influence the PIK3CA pathway. Prostaglandins are associated with tumor angiogenesis, cell proliferation, and inhibition of immune surveillance and apoptosis.

Objectives / aims
This topic will summarize the evidence from clinical trials and observational studies regarding the potential benefits and risks of aspirin for primary prophylaxis. We aimed to determine whether cancer incidence and mortality is reduced by low-dose aspirin.

Methods
For this systematic review, we searched for case-control and cohort studies that reported associations between aspirin use and risk or outcome of cancer. We compared associations from observational studies with the effect of aspirin on risk of cancer death and on metastasis in the recent reports of randomised trials. We extracted data on meta-analysis using data from all randomized clinical trials evaluating low-dose (75-100 mg) daily long-term (minimum three to five years) aspirin regarding cancer mortality.

Results
Four randomized controlled trials (RCT) showed that daily aspirin reduced 20-year risk of colon cancer after a long-term follow-up. Benefit only after 8-10 years of follow-up. (incidence HR 0.76, 95% CI 0.63-0.94) Large meta-analysis showed after a follow-up of four years there was a significant reduction in all cancers independent of age, gender and smoking status (HR 0.88, 95% CI 0.80-0.98) Eight studies showed an association with a reduction in cancer death (OR 0.92, 95% CI 0.85-1.00) Increased risk of major bleeding (gastrointestinal or other extracranial) (RR 1.54, 95% 1.30-1.82)

Conclusions
Aspirin modestly decreases the risk of cancer incidence and overall-mortality, but increases the risk of major bleeding. Very important is the individualizing decision for every patient while considering the net benefit of aspirin prophylaxis.
Background
The increase of the elderly population and the significant drop of birth rates are causing one of the biggest epidemics of the 21st century – the ever increasing rate of dementia and other neurodegenerative diseases. To help address this issue, there is ongoing investigation in robotics, for the purpose of helping the elderly in their tasks and to improve their quality of life. Although this may initially seem farfetched, robots are already showing their usefulness in our day and age. Following significant technological progress, robot prototypes have been developed to become home-mates, monitoring and caring for human beings. Some robot prototypes have already been submitted to clinical trials and have shown positive results, not only in terms of providing support regarding mobility and memory-loss associated problems, but also in the important role of human companions.

Objectives-aims
The aim of this presentation is to show how robots may be a trigger for change in our lives, helping us improve them and to face everyday hardships. This is especially important for those suffering from incapacity, be it physical or mental. By learning about robots, health professionals may advise and consider their use as a complement of other medical activity.

Planned methods
Brief presentation on the robotic prototypes that are already being used in the population and future models and ideas that are being developed.
Background:
Vasco da Gama Movement (VdGM) has been organizing an exchange program of 1 week duration before any National or Regional Congress in Europe in order to promote the Hippokrates Exchange. Spain is one of the most active countries in both activities because the rotation is included in the curricula. This experience helps us to held an exchange during the XXXIII National Congress of SemFYC, from the 3rd to the 9th of June 2013, where 12 European colleagues from United Kingdom, Romania, Italy, Israel, Poland and Portugal were involved.

Methods:
The process to organize the exchange implies to contact the Scientific Society to agree in the number of inscriptions, the Teaching Units to have permission, the tutors to accept the participants in the exchange during the previous days of the Congress in their own practices and the hosts. There is a specific team in charge of this program, which is part of the VdGM Exchange network, and they are working in cooperation with all the different European National Exchange Coordinators (NECs) and the Europe Council to promote the event and select the candidates who will take part in the exchange. Once they have been nominated, participants are distributed among the GP practices that take part in the program and allocated with their hosts.

Results:
11 trainees and 1 junior GP took part in this Conference Exchange, they went 3 days to the GP practices in the mornings, attended a clinical session about women health and communication skills, where they also had the chance to share their own health systems and discuss about them. At the end of the week, they participated in the XXXIII Semfyc Conference in Granada. During these days, they had to 2 guided visits to discover the city.

Conclusions:
Even if you don't have previous experience, if you really want to make it happens is possible to organize a Conference Exchange. It has been a great experience for the team involved and a chance to meet colleagues from all over and learn from each other, improving our knowledge.
Going global - Family Medicine 360º
Ana Nunes Barata
USF Amora Saudável

Background
Exchange programmes are a useful way to cross-pollinate ideas across different geographical locations – in particular, across different cultures. Exchange programs for young GPs and family doctors already existed in Europe thanks to the successful Hippokrates programme. “Family Medicine 360º” wants to be the next step, by taking the concept to a global level. It all started on the 27th of June 2013, at the 20th WONCA World Conference in Prague, where the first meeting for a potential international exchange program for young GPs and Family Doctors was held. Thanks to its success, Young Doctors' Movements from all over the world have been working steadily in order to build a global exchange programme, with educational content.

Objective
“Family Medicine 360º” is a global exchange programme for young GPs and family doctors that has as its goal to promote intercultural dialogue and provide participants with the possibility to learn how family medicine is practiced in different parts of the world, so as to disseminate best practices globally and provide a useful learning experience for young GPs and family doctors. These intercultural exchanges allow young doctors and hosts to be prompted with new ideas that can trigger changes in their own practice and so, ultimately, lead to the improvement of Primary Care.

This session is aimed to give some insight on the “Family Medicine 360º”, how it is structured and what is being planned for it in the future. It also aims to give practical advice to applicants, especially regarding the “Exchange Template”, its steps and its content.

Planned Methods
A brief presentation on the Family Medicine 360º programme, followed by discussion with the audience.
### Challenges of a Residency Training Programme in Family Medicine - The Portuguese Example

Ana Nunes Barata - USF Amora Saudável (Portugal), Joana Paiva - USF FFmais (Portugal), Sandra Serrão - USF Sobreda (Portugal)

**Background:**
Residency programmes after medical school tailor the young doctors and prepare them for practice. Therefore, a well structured residency training programme is essential for good medical practice. That is particularly so in Family Medicine, where the care that is provided is both broad and complex.

In Portugal, the Family Medicine residency programme was established back in 1981, as 36 month long hospital rotations. Since then, there have been great improvements, and it's gone from being similar to a hospital residency to being focused on patient-centred medicine. It is now a 4 year long programme that has been acknowledged internationally and sets a good example to other programmes. In particular, the programme's evaluation method is of particular interest. Residents are constantly evaluated, through many reports and workshops and other activities they must perform, in addition to their yearly exams.

**Objectives/aims:**
By presenting the Portuguese model, this presentation wishes to trigger the audience to reflect on the residency programme in their country and find keypoints that may help to improve it.

**Planned methods:**
Brief presentation on the structure of the Family Medicine residency programme in Portugal and subsequent discussion with the audience of positive and negative aspects of a residency programme in Family Medicine.
Experiences and the utilization of an Urban district Primary health care (PHC) unit in Northern Nigeria
Laminu Kaumi. Mansur Abdulkadir Salisu, Halimah Nuhu Sanda
University Hospital Ramon y Cajal.

Background:
The essence of primary health care is the provision of essential health services and commodities to individuals and communities using available, acceptable and sustainable resources. However, there has been a growing lack of confidence by the populace as evidenced by poor utilization of the services. Health services in Nigeria mirror political organization. The federal government is responsible for tertiary care, state governments for secondary care, and the local governments run primary care. This study aims at understanding the major challenges facing PHC and the utilization of health care services.

Aim:
To assess the real situation and utilization of the primary health care services in three community health care centers of Nassarawa Local government area (L.G.A), Kano Nigeria.

Methods:
A visit to the cosmopolitan Nassarawa LGA of Kano state by 2 Resident Doctors in Family medicine from Spain, within the 16th- 23th of October 2013. With a population of about one million inhabitants and been considered as a commercial center of the second largest city in Nigeria, we chose the 3 largest PHC units, with a 2 day visit to each area. An interview of healthcare workers using a short semi-structured interview schedule. Pictures and assessment of the medical records available, participant observations of health facilities and utilization pattern were used.

Results:
An estimate annual record of 300 baby deliveries is been noticed in the maternity unit. Nevertheless, many women give birth without emergency services or trained personnel and about two-thirds of births occur at home. Child care and newborn care services are not available in most of the units. Lack of drugs and basic laboratory services, and a regular physician on site at the facility were identified as barriers to utilization. Poor health infrastructures with inadequate buildings and equipment’s requiring repairs and regular maintenance were discovered.

Conclusion:
We conclude that the perceptions of poor quality and inadequacy of available services were responsible for low use of PHC services. Therefore we submitted our rapid assessment report and analysis to the Chairman of the L.G.A, considering and emphasizing the improvement of the health services, quality care and develop a high-performing empowered health workforce.
P-005
Development of research competences within the Vocational Training: Croatian experience
Vlatka Hajdinjak Trstenjak, Physician Family Office, Senkovec, Cakovec; Ivana Babic, Physician Family Office; Sveti Martin na Muri, Renata Pavlov, Physician Family Office, Zagreb: Prof Mladenka Vrcic Keglevic, Foundation for the development for family medicine in Croatia Zagreb

Introduction
One of the important aims of Croatian Vocational training (VT) curricula is development of trainees’ research competences. It was mainly obtained during theoretical part of training, postgraduate, master level of course. Fourty teaching hours are delivered through lectures, seminars and small-groups, and additional sixty as practical work on the research projects. The topics covered by the theoretical teaching are: research methods, literature search, critical reading, formulation a research question, choosing research methods, basic statistics, interpretation of results and writing an article. The requirement for the students is to finish and defend his/her research project. The aim of this study was to investigate the characteristics of this research projects. Only the preliminary results are shown in this presentation.

Methods
We check the titles and abstracts of research projects done in period from 2004. to 2012. looking for the types of the projects: research, reviews or case presentations and the contents: organizational issues, quality improvement, prescribing, patient’s health needs, physician’s health, clinical subjects and dealing with specific population groups.

Results
Out of the 651 research project we analysed 420 (64.5%). 82.1% of them are designed as research, 5.2% belongs to the literature review type, and 12.6% are case presentations. The great percentage of the content are related to the clinical subjects (27.9%). 17.4% are related to the organizational issues and methods of work in family practice, such as: practice visits, home visits, referrals and others. In 15.5% of them, the specific family medicine issues were surveyed, such as comorbidity, bio-psycho-social and palliative care. 10.7% were dealing with patients’ health needs or other subjects related to the patients characteristics. The projects related to special population groups (pre-school or school children, elderly, etc.) are not so frequent, 7.6%, as well as projects related to the quality improvements, 7.1%. Topics related to preventive issues (5.0%), prescribing (4.5%) or different characteristics of doctors (4.3%), are even less present.

Conclusion
The Vocational Trainees are mostly interested in clinical and in organizational subjects. Is it important for the development of the family medicine?
The New Italian Hippokrates Exchange Working Team
Rosa Avino GP and Italian NEC, Agostino Panajia GP trainee and REC for Emilia Romagna, Luis Pereira GP trainee and REC for Friuli Venezia Giulia, Luca Caiazzo GP trainee in Emilia Romagna, Elena Fadini GP trainee and REC for Veneto, Elena Benigni GP trainee and REC for Lazio, Jacopo Demurtas GP trainee and REC for Toscana, Lucia Gioia GP trainee and REC for Campania, Giulia Gamboni GP trainee and REC for Umbria, Sara Rigon Junior GP and VdGM Hippokrates Exchange Coordinator, Harris Lygidakis Vasco da Gama Movement

Background
Hippokrates Exchange Enquires from Italian junior GPs and GP trainees are rapidly increasing. Since January 2013 21 Italian doctors asked to participate to the Programme. The VdGM Exchange Programme is run by National Exchange Coordinators (NECs) who represent every nation participating to the Programme and member of the VdGM. In some countries NECs are helped to manage the scheme by a team of colleagues each responsible for a different region or part of the state.

Methods
Last October 2013 seven enthusiastic Italian GP trainees joined the VdGM Exchange Group and were appointed “Regional Exchange Coordinators (RECs)”. They represent 7 different Region from Northern to Southern Italy: Friuli Venezia Giulia, Veneto, Emilia Romagna, Toscana, Lazio, Umbria, Campania. Some Region like Emilia Romagna, were able to engage more colleague into the programme and establish bigger teams working under the guidance of the local REC. All RECs are now collaborating with the NEC and working all together to expand and develop the Hippokrates exchange scheme in Italy. They plan the welcoming of international colleagues, recruit new host practices locally and promote the VdGM Exchange Programmes among their colleagues.

Results
In a very limited time the new group shared opinions, projects and ideas concerning the VdGM Exchange Programme. All the RECs were able to stay in touch and thanks to internet facilities (skype, email, what’ app, tweeter and so on). The Italian exchange group prepared two Operative Documents to improve Hippokrates scheme in Italy, to recruit new Host practices as well as Junior colleagues from other Regions still not represented in the group.

Conclusions
Collaboration among trainee doctors is a great and highly valuable approach to improve Hippokrates Programme. Moreover working in a team is also a unique opportunity to appreciate and improve one’s organizational, collaborative as well as leadership skills. This collaboration has already improved our capacity to respond to enquires of young GPs and trainees who have chosen Italy to participate in the Hippokrates Programme. Furthermore our widespread presence across the country will allow us a better acquaintance of hosts, improving the quality of the programme. In the next future we will work to develop an Italian inter-regional exchange programme in order to promote the dialogue among Family Doctors all around Italy.
From October 9th until October 13th 2013, the Croatian association of Family Medicine (KoHOM), in partnership with the Vasco da Gama Movement (VdGM), organized an exchange for young doctors from all over Europe. This was followed by attendance to the 4th KoHOM Congress in Sibenik.

Prior to the congress, participants were stationed with a GP host working in a Croatian family medicine practice in different cities all around Croatia. The purpose was to observe the daily work of family doctors in this country. During the conference in Sibenik, the VdGM organized workshops and sessions in English that addressed various topics. Amanda Howe, Kenneth Lawton and Richard Roberts, three very passionate GP’s from England, Scotland and the United States, respectively, contributed to the discussions in a very inspiring way. Furthermore, a substantial part of the congress was also translated into English.

The experience was highly valuable. Thanks to the availability of the Croatian hosts, participants were able to learn in detail about the Croatian Primary Health Care System, its foundations and practice. Participants also had the chance to observe and discuss at length many differences and similarities between Primary Care and Health Care Systems in general, learning not only from the Croatian hosts but also from each other. The knowledge exchange was bilateral, as the hosts in Croatia also discovered 11 different Health Care Systems in just one week.

Successful experiences such as these act as triggers for change. Thanks to the enrichment that they provide, they act as a source for new opinions and ideas. These experiences highly motivate intercultural networking for future collaboration - this poster being a practical example of this.
In 2002 the Irish College of General Practitioner (ICGP), the National Representative body for all GPs in Ireland, recognised the need for a support network for establishing GPs. Not only was there a demand from establishing members for more targeted support, but the college had also identified that establishing members had specific needs. From this grew the Network of Establishing General Practitioners (NEGs). Following a series of meetings and symposia, NEGs was formally launched in June 2004 with the appointment of its first Programme Director. Now celebrating its tenth year in existence, this presentation will give an overview of how the ICGP set about developing a support network for its establishing members, the changes that NEGs has undergone in the last ten years from its simple beginnings, and the future vision and direction for support that the current Programme Director and ICGP leadership has for the Network. The presentation will also give an overview of the current supports that are in place within NEGs including formal linkages with Irish GP Trainees, regular regional and national meetings, a closed community online discussion forum and a network of regional representatives. The presentation will also highlight the key issues that are impacting upon establishing GPs in Ireland and the importance for NEGs of having a dedicated funded Programme Director who is an establishing GP and has direct access to senior management and the Executive of the ICGP. Finally, the presentation will touch briefly on how NEGs is developing Irish links with the Vasco da Gama Movement.
Vasco da Gama Movement (VdGM) is under the structure of WONCA Europe. It includes family physicians within the first five years, and trainees. It is working for the benefit of these young doctors. In June 2004, during the WONCA Europe Congress in Amsterdam a pre-conference was held under the name of Junior Doctors Project. At this meeting, Turkey was represented by Nil Tekin, Fatma Gökşin Cihan and Erhan Burgut. It was the first pre-conference that VdGM was created in 2004.

Leading representative members of VdGM Turkey were: Nil Tekin (VdGM Europe Council Member) and Fatma Gökşin Cihan (VdGM Executive Group Member). In 2009, Nil Tekin had transferred this mission to Zelal Akbayın. In parallel with VdGM Europe, this movement was structured in Turkey also. Leading this re-organisation, coordinators of Turkey had changed as: VdGM Turkey Exchange Coordinator Özgür Erdem, VdGM Turkey Research Coordinator Hüseyin Can, VdGM Turkey Education & Training, and also Image Coordinator Hayriye Külba and VdGM Turkey Beyond Europe Coordinator Murat Altuntaş.

Now, Berk Geroğlu is new representative for Turkey and new team (Exchange Coordinator Demet Merder Coşkun, Research Coordinator Fikret Merter Alanyalı and Education & Training Coordinator Canan Tuz) working since October 2013. The main theme of WONCA Europe Conference 2015 Istanbul is determined as “Future of family medicine... Being young, staying young...”. It proves the value given to young family physicians in our discipline.

With the works of Exchange Group in last 5 years, Turkey has been represented in fourteen different Exchange program in Europe countries such as United Kingdom, Spain, Portugal, the Netherlands and Denmark. Also, we had European colleagues that had visited our country with an exchange programme. Workshop preparations has been started lately for WONCA Europe Conference 2015 Istanbul.
The aim of the family medicine is to train specialists equipped with five-star physician characteristics. These five stars are: 1) to improve the patient management skills 2) to be accustomed to community based care 3) personal care 4) to increase proficiency in patients 5) to evaluate patients with biopsychosocial environment.

In Turkey, the family medicine residency programme consists of hospital rotations, primary-care practices and educational activities. Hospital rotations include professional practice that is essential especially when working in urban. Primary care practices is another way to improve the patient management skills and to queried with symptoms related applications. On the other hand, it has been released that the family medicine residency programme is weak in some specialities. For example: Terminal patient care, adolescent healthcare, newborn primary care, drug abuse, violence, environmental-related diseases, occupational diseases and homecare.

Family medicine is a comprehensive expertise. It’s the responsibility of both the individual and the family. For that reason, it would be appropriate to include these identified issues to the educational activity of family medicine residency. According to the study of Yılkıran H et al. at 2012; the 40.3% of assistants in family medicine in Turkey are planning to have a career on this discipline. One of the main features of the scholarship is to stay update with the habit of reading articles. Nevertheless, the participants are not aware of how important to read an article in Turkish or English. Same participants are aware of just reading Turkish articles is not enough for the professional development. When they asked about the level of English; 81.9% of participants agreed upper-intermediate level of English. It’s a paradox that even if they have the ability of a foreign language, they don’t have the habit of reading articles in English.

In terms of family medicine residency training methods, one of the most important features is to have collateral mission with the trainees. The context should be renewed with the needs of the participants. When planning the educational activities, it’s important to announce the targets before the academic calendar in order to check what if the trainees have new ideas or targets about the programme. The main targets should be discussed by the trainees and trainers according to the benefits of the professional care after graduation. Also, it could be considered that trainees should improve themselves by the help of the regular feedbacks. Expertise in all phases of training must be provided to appropriate learning environment.
Manchester Triage System (MTS): experience from an Accident and emergency (A&E) department of a tertiary Hospital
Mansur Abdulkadir Salisu, Laminu Kaumi, Halimah Nuhu Sanda
University Hospital Ramon y Cajal, Madrid Spain.

Background:
Emergency service represents an important component of the Spanish public health system. To the reality of overloaded A&E, is very important to have a reliable triage system. MTS was implemented in our hospital since June of 2009. It allows evaluating each patient by using the clinical patient risk classification criteria layer. However, it’s frequently being selected as the route of primary access to the healthcare system.

Aims and objectives:
To describe our experience and consultation activities at the Accident and emergency (A&E) department assessed by nurse triage using the Manchester triage system (MTS).

Methods: This is a retrospective descriptive study undertaken over 12 months between January 1, 2010 and December 31, 2010 on patients (adults and children) that presented the busy inner city A&E department of Ramon y Cajal University Teaching Hospital, Madrid Spain. It’s a quantitative survey where data collection was done through attendance records of adults and children up to 24hrs in the institution. Patients characteristics, selected flowcharts, discriminators, and urgency category were recorded in the MTS. Selection of a discriminator indicates one of the five urgency categories, with a maximum waiting time ("immediate" 0 minutes, "very urgent" 10 minutes, "urgent" 60 minutes, "standard" 120 minutes, and "non-urgent" 240 minutes).

Results:
Nurses triaged 133,310 patients using the MTS, where 57% of patient were given triage category standard, followed by 32% as urgent, very urgent 9 %, non-urgent 1% and immediate 0, 8%. The most frequent presenting complaints were: worried patient (14%), leg swelling (13%) and abdominal pain (8%). Commonly used general discriminators were pain discriminators (33%), recent problems (17%), recent injury (6, 3%) and fever discriminators (1%); commonly used specific discriminators were increased work of breathing (3%), history of red eye (3%) and persisting vomiting (1%). High ER visits were considered in the month of May 9% (n= 12038) and March 8, 8% (n= 11,739), whereas the least visited month is august with 7, 3% (n= 9799).

Conclusions:
Most of the patients triaged as standard and non-urgent level that attended A&E department could have been treated in a general practice setting. Our experience in this study may contribute as an improvement model related to the reality of overloaded A&E department of a tertiary Hospital.
A Disease Management Programme Using Integrated Clinical Pathways

Lim Fong Seng
National Healthcare Group

Background
Patient care in busy clinics is variable and lacking coordination among the various healthcare team. A disease management programme was piloted to have nurses use well-defined clinical pathways developed by doctors to manage diabetics and take some load off the overworked doctors. The nurses were closely supervised by the doctors who provided leadership. The pathways defined clearly the various treatment steps to be followed and the roles of each member of the multi-disciplinary healthcare team.

Objective
To evaluate the effectiveness of the disease management programme, compared to the usual management, in managing diabetic patients with hypertension.

Methods
Control of hypertension in 44 diabetic patients in the disease management programme was compared with 91 diabetic patients under usual care, after a 6-month follow-up.

Results
54.5% of patients in the disease management group showed improvement in blood pressure (BP) control while 44% of those under usual care showed improvement, after 6 months. In the disease management group, there was an average decrease of systolic BP of 7.9mmHg and diastolic BP of 2.4mmHg while those under usual care had an average decrease in systolic BP of 2.1mmHg and diastolic BP of 1.7mmHg.

Conclusion
The disease management programme is as effective as normal care, in managing diabetic patients with hypertension. Family Physicians need to provide clinical leadership to new clinical programmes to ensure success. Well-defined clinical pathways detailing the various roles of the healthcare team aid in integrating care for patients.
### P-013

**Relevancy of Non-ST Segment Elevation Myocardial Infarction diagnosis by medical emergency care mobile unit: The "SCAN-SAMU 76A" Study**

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**Introduction:**
The emergency physician practicing in the out-of-hospital setting is often the first to diagnose the coronary chest pain based on patient’s history, symptoms and electrocardiogram. Specific epidemiological data on taking charge of Non-ST Segment Elevation Myocardial Infarction (NSTEMI) in the out-of-hospital setting are missing. The objective of this study was to assess the relevancy of diagnosis of NSTEMI in this situation.

**Methods:**
The study SCAN-SAMU76A is a mono-center, retrospective non-interventional study, with multivariate analysis, conducted over a period of three months, from 1st of June to 1st of September 2013. Primary outputs of 1351 out-of-hospital physician staffed emergency care mobile unit interventions were analyzed. 132 suspected NSTEMI patients were included in the study. For each patient, the collection of out-of-and in-hospital data were collected.

**Results:**
Within the suspected NSTEMI patients, 51 were confirmed when making the diagnosis (38.6%). Among them, 98% had a high average probability of NSTEMI in the out-of-hospital setting. In 70.6% of cases, patients received treatment initiated before the hospital admission. Among the patients in the MI+ group, for 64.7% the Cardiac ICU was the primary destination, bypassing the Emergency Department. The Cardiac ICU was the secondary destination for 31.4% after initial ED setting. Finally, in all patients included to confirm the diagnosis of myocardial injury, 130 patients (98.5%) had an initial troponin assay, and for 103 (78.1%) troponin kinetics were performed.

**Conclusion:**
In our study, 38.6% of out-of-hospital diagnoses of NSTEMI were relevant. The use of a single probability NSTEMI score seems to be a significant help in choosing the most suitable track for these patients.
Validation of Predictive Testing for Organic Dyspepsia in Fuerteventura Island.

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Background
The clinical validity of the presumptive diagnosis for causes of dyspepsia by doctors is low at around 55-60%. This percentage increases when it comes to patients with functional dyspepsia, and that the prevalence is higher and this implies a higher positive predictive value (PPV) (about 70-75%). By contrast, the PPV for the organic dyspepsia is lower (30%). These results indicate that the probability of diagnosing functional dyspepsia is high, do not be so in the case of organic dyspepsia.

The Barenys test shows a superior discriminative value for organic dyspepsia (75%) compared with the diagnosis of clinical suspicion (69%) and even test H. pylori (61%). Clinical practice guide, 2003; recommends validation of this clinical model in other geographic areas as a preliminary step to their implementation globally.

Objectives:
To validate the Barenys testing, (2003). Offering a scientifically proven tool that optimizes clinical diagnosis of upper gastrointestinal endoscopy demand (UDE).

Methods:
Patients aged between 18 and 85 years with dyspepsia (Collins, 1988) Exclusion Criteria: Patients who consult exclusively for heartburn - Patients who do not meet the inclusion criteria. Group A: Patients were recruited prospectively consultations AP medical reviewers, for a period of eleven months. Group B (Control) Patients referred to gastroenterology for upper digestive endoscopy routinely by primary care physicians. Initially primary care physicians in group A and the gastroenterologist patients receiving conducted a clinic visit that will include a through model and endoscopy is performed with urease test. Patients in group B were only performed endoscopy with urease test. Patients were classified in EDA Positive / Negative; infected / uninfected. The endoscopy has to be done in no more than 10 days after patient recruitment. Interventions: Upper Digestive Endoscopy and Urease Test. Analysis: ROC curves to determine the sensitivity and specificity Student T Test

Results:
Organic causes of dyspepsia and H. pylori positive, concentrate from the cutoff points 6 and 7 with Sensitivity of 81% and 62% and Specificity of 18% and 43% for cut point 6 and 7 respectively. Postibe Predictive Value 50% and 43% and Negative Predictive Value 53% and 50%.

Conclusions:
Are expected to implement the application of the test in primary care.
Statin’s Prescription in Primary Prevention: A Clinical Audit in General Practice
Rosa Avino GP trainee in Trento (Italy), Claudia Prevedello GP in Pergine Valsugana (Italy), Guido Fruet GP in Pergine Valsugana (Italy), Antonella Fruet GP in Pergine Valsugana (Italy), Eduino Bonincontro GP in Pergine Valsugana (Italy)

Background
Cardiovascular disease due to atherosclerosis and to thrombosis is the main cause of premature death and disability in Europe. Causes are multifactorial and Dyslipidaemias represents one of these. Lipid-lowering treatments, like Statins, are prescribed according to patient’s cardiovascular risk estimation. This Audit involved 4 Italian General Practitioners (GPs) working in the North of Italy. The study analysed a group of patients on Statins and set a shared modification in the way GPs will manage patients with Dyslipidaemias for a six months interval. The study was prepared by Dr Rosa Avino at the end of her vocational training in General Practice.

Methods
Data analysed were collected from Millewin, the electronic medical record used by the GPs involved. There were done 4 data mining and each GP received an envelope with 8 documents concerning the latest revisions on the management of patients with Dyslipidaemias. GPs used this supporting material for the six months to go, as expected.

Results
The first data mining collected 44 patients on Statins, according to the criteria selected. For all patients there were no data recorded about cardiovascular risk estimation. This was the main point to work on. After six months It was done a new extraction and data of 5 patients on a new therapy with Statins were collected. For all of them cardiovascular risk rate was recorded. Two more data collections were done. One to evaluate for how many patients GPs recorded the cardiovascular risk rate during the six months. There were collected data of 125 patients. The second to evaluate if there were patients with high cholesterol levels (>280mg/dl) not on Statins. Data of 35 patients were analysed.

Conclusions
There are many documents to manage patients with Dyslipidaemias (Guidelines, Cardiovascular risk estimation cards, Italian AIFA’s prescription annotations). This background material can be used in the daily clinical practice efficiently. After only six months, it was possible to observe that a structured and shared management of the patients could be strongly valuable in order to appropriateness.
The Adherence of GPs to New Guideline of Type 2 Diabetes Management in Ukraine

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Objective
The diabetes prevalence increases annually in Ukraine and was 1.3 million of people in 2012. Until last years the type 2 diabetes (DT2) management was conducted by endocrinologists in Ukraine. Now Ukrainian health system is under intensive reformation on family medicine principles that supposes passing of diabetes management to general practitioners (GPs). We created National guideline and clinical protocol of diabetes primary care, which are based on international guidelines. The protocol and guideline were approved by the order of Ukrainian Health Ministry №1118 from 21 Dec 2012.

The aim of our study was to determine levels of adherence of GPs to new guideline for DT2 management.

Methods
We conducted a survey between 32 general practitioners (49.6±2.5 years old, 3.1±0.6 years of work, 22% rural, 88% urban) about their adherence to new guideline of DT2 management. A standardized self-completion questionnaire, adapted to Ukraine, was used to collect data from participating GPs. Statistical analyses was conducted by Excel 2007, SPSS.

Results
Our survey showed that in condition of reformation GPs have about 23.2±5.6% patients with DT2. But 1 year after new guideline implementation only 56.3% of GPs know about its existing. 53.1% GPs prescribe oral glucose-lowering medications by themselves, but not insulin therapy. 93.7% GPs have good access to other specialist (75% in their practice) and can provide multidisciplinary team care. 84% GPs propose education for patients. Target achievement was low: with only 53.6% patients having HbA1c ≤7%; 23.6±2.5% patients having blood pressure ≤140/80, 77.6±4.9% of them with antihypertensive prescribing; 34.5±4.9% patients having cholesterol ≤4.5mmol/l and 65.1±5.3% of them were prescribed lipid-lowering medication.

Conclusions
The adherence of GPs to new guidance for the management of type 2 diabetes was not so high in early stage. The situation needs further improvement and analyses. We have suggested the manual of diabetes primary care with printed new guideline that helps Ukrainian GPs to conduct effective diabetes care.
The Prevalence of Cardiovascular Risk Factors in Patients with Diabetes 2 and Adherence of Patients to Using Prevention of Cardiovascular Pathology

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Background
The prevalence of diabetes is growing steadily every year. Cardiovascular diseases are the reason of death in 75% of patients with diabetes. The aim of study was to establish the prevalence of cardiovascular risk factors among the patients with diabetes type 2, adherence of patients to using prevention of cardiovascular pathology.

Methods
We have analyzed anamnestic data of 40 patients with diabetes type 2 of moderate severity (21 men and 19 women, aged from 59,7±1,38 years, duration of diabetes 10,62±1,2 years) with an accent to presence of cardiovascular risk factors. The blood pressure, body mass index (BMI), levels of lipids, HbA1c and ECG were analyzed. Also the use of medications for cardiovascular disease prevention, the actual compliance of patients were studied. Statistical analysis was performed using Excel 2010.

Results
The cardiovascular risk factors were present in all examined patients with diabetes: increased BMI – 31,92±0,58, increased cholesterol – 5,84±0,2 mmol/l, dislipidemia, hypertension (blood pressure 142,7±1,17/ 78,9±0,8 mmHg), increased HbA1c – 8,49±0,25%. Only part of the patients really received prescribed treatment: 92,5% – antihypertensive medications, 10% – statines, 57,5% – acetylsalicylic acid, this was caused by low knowledge of patients with regard to strict necessity of their use. In the result, 11 (27,5%) patients had a history of myocardial infarction after 11,7±2,44 years of diabetes onset, another 20 (50%) – stable angina after 4,2±1,15 years of diabetes onset; these patients had higher levels of cholesterol, HbA1c, BMI then others on the moment of the study.

Conclusions
The high prevalence of cardiovascular risk factors in examined patients with diabetes type 2 is accompanied with low adherence of patients to using prevention recommendations cardiovascular diseases that requires improvement.
Spontaneous Mediastinal Emphysema: A Case Report

Paloma Rodríguez Turégano, Casandra Cantera López, Belisa Tarazona Chocano, Enrique Revilla Pascual, Concha Díaz Laso.


Background:
Spontaneous pneumomediastinum or Hamman Syndrome is an uncommon disease. Its clinical manifestations are dyspnea, chest pain and subcutaneous emphysema. It usually affects young and healthy patients without any apparent precipitating factor. It usually has a benign evolution. Hamman Syndrome is frequently misdiagnosed.

Case report:
We report the case of a 21-year-old woman who attended emergency service complaining of mild dyspnea, rhinitis and abrupt pleuritic chest pain irradiated to neck and back without previous trauma, drug use or exercise. Physical examination and vital signs were normal. Chest and neck X-rays showed subcutaneous emphysema. Pneumomediastinum was confirmed by thoracic CT scan. The patient was kept under observation and was discharged home after 24 hours with an improvement of her symptoms. Conclusions: Spontaneous pneumomediastinum should be taken into account in the differential diagnosis of chest pain. It is usually a benign entity and conservative treatment is indicated. Emergency physicians and thoracic surgeons play an important role in its diagnosis and management.
Turkish Family Residency training has firstly started in 1985 at few hospitals. Today there are 43 medical school hospitals and 19 training and research hospitals which provide family medicine residency programme in Turkey. In 1990, Turkish Association of Family Physicians (TAHUD), an association that represents family physicians was founded in Ankara. Lately, with its different branches, it keeps working on regional and national activities. Even in residency you can subscribe to this association, thanks to that residents are effective in activities, with specialists and academicians they can build warm relationships and have benefit from their experiences.

In 2009, Turkish Association of Family Physicians Istanbul Office Residents’ Platform: FAMILYA was established. In time, it spread among residents, and had changed regional status into national. Now it’s called as Turkish Family Medicine Residents’ Network.

The member count is 557 now and it’s still rising also there is no fee demanded. The leader of FAMILYA is been selected only from active and dynamic residents. Recently leader of FAMILYA is also the National Exchange Coordinator of VdGM Turkey.

Purpose of FAMILYA; provides family medicine residents acknowledge the discipline of family medicine well, announces and encourages attendance to all professional, academic, social and cultural activities, builds up cooperation between residents and specialists in family medicine and ensures an environment that residents can freely share their ideas, suggestions, questions and problems. For this purpose, from all hospitals there are selected active members who will share the basics of discipline, publicize societies and organisations like WONCA, VdGM, TAHUD and FAMILYA to beginner residents. Thus, it raises awareness and make residents be part of this network at the beginning.

The mail group of FAMILYA is asistanailesi@googlegroups.com. In this group there are news that announces national and international congresses, seminar and courses, attendance terms and bursary possibilities.

FAMILYA opens stalls in annual national congresses for developing communications between residents and plans workshops. In 2012, the first Family Medicine Residents Congress had been organized by FAMILYA in Istanbul was a big success.

There are more examples of this kind of national young doctors’ groups around the world. With supporting these groups and it’s members who wants to be in communication, develop knowledges and give a direction to the discipline, there will be remarkable benefits not only to individual residents but also to community health.
School health program 2.0, a community health program that resolves unmet needs for health care among young primary care patients.
Cruz Muñoz Vanessa, González Santalucía Lara, Valls Ibáñez Victoria, Urquizu Rovira Marta, Román Rodríguez Antonia, Sánchez García Ana.

Background
Social networking sites have changed the communication landscape, especially for the youth. Taking advantage of the affinity of adolescents with new information technologies, Facebook is seen as an appropriate tool to reach teens and to deliver health promotion messages.

Objectives:
- Assess the participation of adolescents to consult health issues through facebook.
- Describe the breadth of these activities.
- Collect more issues that concern teens.

Methods:
Cross sectional study in the period 22-10-2012 to 21-08-2013. Facebook profile is created with confidentiality requirements, and a secure social network. Inclusion criteria: adolescents of 3rd and 4th Compulsory Secondary Education courses belonging to Nord Primary Health Care center, urban setting.

Results:
Open consultations on facebook are: curiosities, health-illness, sexuality, sexually transmitted diseases, nutrition-hydration, smoking, alcohol and drugs, tattoos, contraception and emergency contraception. Private practice include: emergency contraception, health-illness, sexuality, menstrual delay, nutrition-hydration and contraception. The demand for emergency contraception has been done through private messages. Our Facebook site received more inquiries than four years of face to face consultation program appointment (community health program). Sexuality issues account for most queries.

Conclusions: Teenagers have prejudices when making face to face consultations especially on sexuality issues, but not through virtual consultation. Results indicate that this social networking site resolves unmet needs for health care among young Primary Care patients, so we should promote it.
Cultural Differences: How Much Do They Lead To Eating Disorders?
Bozoklu Gulhan, Caylan Ayse, Dagdeviren Hamdi Nezih
Trakya University, Department of Family Medicine

Background
Abnormal eating behaviour is an impotant public health problem in Turkey as well as in the world which clinically deteriorates physical health and psychosocial functioning presenting itself as eating habit disorder. To determine the reasons leading to eating disorders evaluation of the individual’s eating behavior is important. In many studies related to the etiology and epidemiology of eating disorders, low self-esteem and negative body image has been shown to affect eating behaviour.

Objectives
The aim of this study is to establishe the relationship between the eating disorders and affecting factors with body image and self-esteem and to reach the datas and results that simplify the diagnosis and treatment of eating disorders and help in improving the quality of life with holistic approach in primay care.

Methods
It will be a prospective and descriptive type of study. A questionnaire containing demographic information, 'DEBQ (Dutch eating behavior questionnaire)', 'Rosenberg self-esteem scale' and 'body image scale' will be performed with a face-to-face interview by the researcher. 18-65 years old adult volunteers will be included in the study and sampling will be done by stratification method.

Questions:
Are there any similar studies present in different parts of Europe?
Any other suggestions to improve this study?
Health Related Quality of Life Among Infertile Women
Yucel Ayca, Caylan Ayse, Dagdeviren Hamdi Nezih
Trakya University, Department of Family Medicine

Background:
Infertility rate in the world is 8-12% and in Turkey this rate varies between 10-20%. Infertility is a crisis situation for all cultures. Infertility is particularly serious and is a major problem because of social pressure in developing countries with the high prevalence of infertility. In research, infertility causes loss of confidence, health deterioration, decrease in hope and deteriorate relationships with other people in women, which is why depression, anxiety, feeling guilt and resentment is higher than has been reported in women again. Knowing the psychosocial problems experienced in infertility treatment process, may facilitate individuals adaptation to infertility and its treatment process, so the chance of success in the treatment may increase.

Aims and objectives:
In this study the aim is to determine the quality of life of women in case of infertility because infertility affects women’s health and quality of life.

Methods:
Questions containing socio-demographic information prepared by the researcher and ‘Fertility Quality of Life Questionnaire’ will be implemented through face to face interviews. Planned research methods are prospective, cross-sectional and descriptive type. The study will include 340 infertile women. The research will be held with the applicant of infertile women volunteers in Trakya University Hospital Research Centre for Assisted Reproductive Techniques.

Questions:
Do the volunteer participants with primary and secondary infertility have different quality of life results, will this affect the significance of the research?
The Impact of Pregnancy on Mother’s Health and Quality of Life
Taymez Fatos, Caylan Ayse, Dagdeviren Hamdi Nezih
Trakya University Department of Family Medicine, Edirne, Turkey

Background
Gestation period when physiological, psychological and social changes occur and adapting to these changes, is an important process of female life. The changes before and after the pregnancy, various problems can be experienced by pregnant women and can cause health deterioration. Family physicians can easily notice the mental and physical changes during pregnancy and help with a holistic and continuous approach. During this period the duty of family physician is to perform the regular pregnancy follow-up to evaluate the risks related with pregnancy and to prevent of complications that may occur.

Objectives/aims
The aim of this study is to investigate the socio-demographic characteristics, expectations from pregnancy, pregnancy-related anxiety and anxiety levels, family status and their level of social support and quality of life of the pregnant women in the first trimester. In addition at the end of the study to achieve the results and data which will help in elimination of anxiety that may arise during pregnancy, giving a healthy birth and improving the quality of life.

Methods
In the first trimester pregnant women who agreed to participate in this research, demographic data questionnaire, Multidimensional Scale of Perceived Social Support (MSPSS), state and trait anxiety inventory (STAI 1-2), social support scale for pregnancy birth and the postpartum period, Beck depression scale for primary care and WHOQOL quality of life scale questionnair will be implemented by the researcher with face to face interviews. The research methods are planned as prospective, cross-sectional and descriptive type. The pregnant women in their first trimester who are applied or registered to family health centers of Edirne between the date of March 2014 - February 2015, will be included in this study.

Questions:
Is there any similar study in other countries?
Have you any other suggestions for this study?
Infant of 11 Months with Vomiting, Irritability and Loss of Function in Right Upper Limb

Mansur Abdulkadir Salisu(1), Laminu Kaumi(2), Regina Sandra Benavente Cantalejo, Dolores Pineda Dorado(1)

1: Hospital Merced Osuna-Seville, Spain 2: Hospital Ramon y Cajal, Madrid, Spain

11 months Female infant with no past medical history, properly immunized according to age, pregnancy and birth without complications, no previous hospital admission, birth weight 3,200 g, mixed breastfeeding. Complain of 2 weeks vomiting food content (several episodes per day). At the start reviewed in ER for vomiting during 2 days, no fever, and no diarrhea. Physical examination and laboratory findings were normal. (Blood count, urine studies, biochemistry and normal CRP). Abdominal ultrasound: No significant findings except abundant abdominal bloating. One week before admission, persistent vomiting query again by adding local pain in right arm without a history of trauma, with normal basic study (CBC and Biochemistry) Plain radiography of right elbow-shoulder without findings.

Given the persistence and progression of functional disability in right upper limb patient was admitted in hospital for studies & adequate management. On observation the affected arm remains immovable, extended throughout the body and later 24-48h paresis of Right Lower Limb. Vomiting limited after 10-14 days of onset and afebrile at all times.


Neurological Examination: Content. Smiling and connected with the environment. Glasgow 15/15. Pupil’s normal size and reactive to light. EOMC. Normal cranial nerves. Flaccid paralysis in right upper limb (Reflex non assessable). Right lower limb with symmetrical paresis reflexes (patellar and alquileo) and asymmetric mobilization regarding contralateral limb. Resting posture with Right upper & lower limbs, both extended. Conserved axial tone with established head control.

Performed on admission head CT: Space occupying lesion in Frontal Lobe and left basal ganglia, which invades the body of the Lateral Ventricle Left, moves and invades the left frontal horn, 3rd ventricle, monro’s hole with ventricular enlargement. Moving midline to the right.

Diagnosis: Glioblastoma multiforme (Brain tumor)
Necrotizing fasciitis of the eyelid caused by Streptococcus pneumoniae.

B. Zama*, T. Kalo**, Artenca Collaku***

* Faculty of Medical Sciences, Medical Doctor, University of Tirana. ** Service of Infectious Diseases, Infective Doctor, University Hospital Center “Mother Teresa”. ***Service of Family Medicine, Family Doctor, Clinic Number 4, Tirana.

The purpose of this presentation is to report the occurrence of a rare case of necrotizing fasciitis of upper eyelid caused by Streptococcus pneumoniae.

Introduction:
Necrotizing fasciitis (NF) is a rare life-threatening disease characterized by the pathognomonic association of rapidly progressing necrosis with edema of the subcutaneous tissue and fascia and extensive undermining of the skin but sparing of the underlying muscle and potentially fatal accompanied by systemic signs of toxicity, which it is mainly observed in legs and abdominal wall, but rarely in the other part of the body such as face and neck. NF is more frequently polymicrobial and a combination of aerobic (streptococci and staphylococci) and anaerobic bacteria, often lead in a quick and severe progression of the disease. Soft tissue infectious diseases caused by S. pneumoniae, especially NF are rare and few reports document such association.

Case report:
A 43 years old man, immunocompetent, non-smoker, presented to the emergency service of Infectious Diseases Department after a period of 12 hours of shivering during the night and in the early hours of the morning, complaining of pain and swelling of his left eyelid including the face. There was no history of insect bite or trauma of that area. The oral temperature was 39.2°C, pulse was 94 beats/minute, respiratory rate was 27 breaths/minute, and blood pressure was 96/47 mm Hg. There was no nuchal rigidity or lymphadenopathy. The left part of face was significantly edematous, with erythema and few bulous elements filled with a serohemorrhagic liquid, as well as induration going down up to mid-neck. It was extremely tender, and no passive movement could be elicited. Initial laboratory investigations showed a white blood cell count of 18,300/mm3 (79% neutrophils, 16% lymphocytes, and 5% monocytes), hemoglobin concentration of 11.5 g/dl, hematocrit of 34.5%, and platelet count of 259,000/mm3. Liver chemistry values were within normal limits. Necrotizing fasciitis was suspected clinically and Ceftriaxone plus Metronidazole were started immediately. Streptococcus pneumoniae was isolated in one blood culture and liquid of vesicles. The outcome of NF was towards a total recovery after a local plastic surgery, as well.

Conclusion:
The bacteria that cause NF act quickly, infecting the victim within twelve to twenty-four hours. NF leads inevitably towards a severe sepsis and multiple organ failure with a high mortality rate (12-57% of cases), which needs an early diagnosis besides of a promptly and aggressive medical and/or surgical intervention.
Background
Clinical leadership is a vital part of GP’s work. Effective clinical leadership improves patient outcomes, and patient and provider satisfaction. Most medical schools provide little or no structured leadership or management training for young doctors. Existing programmes are usually limited to one specialty. We describe an innovative management programme developed at the University of Helsinki.

Research question
How to support clinical leadership of GP trainees?

Methods
Setting: Since 2009 a management development programme of 30 ETCS is mandatory for all physicians in specialty training at University of Helsinki. The aim is to obtain knowledge, skills and attitudes of frontline clinical managers. The design is based on principles of experiential learning. The individually planned programme can be completed during the specialist training, in 3-5 years. An e-learning platform and e-portfolio enhance individual planning, tailoring, reflection and evaluation of learning.

Results
Junior doctors specializing in general practice form the biggest group of learners. Each learner has a licensed GP as mentor. Real-life experiences of the young doctors and case-based learning methods are used. Both individual and shared reflection is endorsed. Group reflection and discussion among young doctors aiming at different specialties receive positive feedback. Practice-based improvement projects allow active experimentation and create new concrete experiences. Improvement projects can be related to service delivery, e.g. development of house rules or care pathways, or personnel management, e.g. introduction file for new personnel. Evaluation of improvements in learning and practice will be gathered.

Conclusions
The competence-based programme covers all specialties. It offers a platform for discussions between general practice and hospital specialties. The chosen learning methods are supporting both learning and improvement of care.
# PERSONAL SKILLS

**P-027**

**Development and Utility of Resource Materials for Establishing GPs in a National Support Network: Helping other Countries learn by Comparing the Danish and Irish Experience.**

Ulrik Kirk, Peter A Sloane

The Danish College of General Practitioners (DSAM) The Irish College of General Practitioners (ICGP)

## Background

Denmark and Ireland are similar in terms of population size, medical practice and infrastructure. Both also have populations of newly qualified GPs that can often feel overwhelmed as they move from being GP trainees to qualified GPs. As Davies et al. describe in *The New GP's Handbook*, this process can feel like “falling off a cliff”.

For ten years, under the auspices of the Irish College of General Practitioners (ICGP), Ireland has had a formal support structure for establishing GPs, the Network of Establishing General Practitioners (NEGs). In 2008, shortly after NEGs was set up, and with limited consultation, a handbook for establishing GPs, *Signposts to Success*, was published in hard copy. The content is therefore fixed from the time it was published. Since 2008, there has been rapid change within Irish healthcare and General Practice, and despite being of great value, *Signposts to Success* has become outdated. In contrast to Ireland, the Danish College of General Practitioners (DSAM) adopted a very different approach, publishing an interactive electronic handbook for newly qualified GPs, *Praksis Plus*. This followed extensive consultation with establishing GPs within DSAM, including the holding of focus groups. The end result was a dynamic interactive electronic book which can be easily and efficiently kept up to date.

## Methods

This presentation will give a brief outline of the process by which *Signposts to Success* and *Praksis Plus* were developed, compare the processes by which each was published, and comment on the utility of each. The weaknesses and deficiencies of each will also be identified.

## Outcome

By comparing and contrasting the Danish and Irish models and methods of development of a support publication for establishing GPs, the audience will understand the key elements required to develop a similar type handbook within their respective national organisations.
Background and aim. EQUIP-VDGM has started its work with looking for choices to develop leadership and training of young family physicians [FPs] and trainees.

Methods. 60 study publications including questionnaires, surveys and meta-analysis in Medline Database and Virtual Mentor Database were gathered and analyzed.

Results. The role of family medicine and FPs is often overgeneralized, excluded in publications and treatment recommendations. Studies show global burnout among young family physicians and trainees, moralization involved in training and stigma towards family medicine, which require an urgent need to look for new ways to develop training and the capabilities of new leaders in primary care. Emotional intelligence and six ways of leadership are mostly studied and observed in primary care practice teamwork and system of its hierarchy. IPE is relatively young branch in medicine; however, reflective coaching has demonstrated its positive effects, developing confidence and traits of leaders. This policy flows directly from the mission of medical schools, it suits a positive notion of social justice and is also compelled by a duty not to discriminate on arbitrary grounds, and educators who steward educational institutions must have the moral courage to place considerations of institutional mission and social justice above the political views and negative responses of some alumni and donors [Kuczewski, Brubaker, 2013].

Conclusion. Young specialists in primary care need to be treated equally by trainers of other medical specialties. For now only encouraging, supporting way of training, using reflective coaching suggest perspective to the future leadership in primary care. EQUIP-VdGM working - group suggest the Wonca and WHO to look for resources to advert family medicine and improve inter-professional relations worldwide.
PERSONAL SKILLS

P-029
GP’s around the world: Sharing our thoughts.
Rodriguez Benito Laura, Conde Valvis-Fraga Sara, Nieto Virginia.

Background:
Vasco Da Gama Movement is the WONCA Europe working group for new and future General Practitioners. Its main objective is to establish a communication network among European trainees and new GPs and identify their concerns, doubts and needs. They organize a wide variety of activities: exchanges, Pre-Conferences, Forums etc. In brief, they promote GP’s intercultural learning.

During the last Conference-exchange, RCGP-JIC Harrogate 2013, 17 people (GP in their First 5 and trainees) enjoyed, for a whole week, different multicultural activities such as debates, plenary sessions, and poster presentations. We also visited an English health Centre and took part in a variety of social events that let Vasco Da Gama members get a closer idea of GP’s duty in different countries.

Methods:
After participating in the last Vasco Da Gama Exchange in RCGP Harrogate October 2013, we asked every participant to answer, via email, the following question: “How do you think this experience has influenced you in your personal and professional development as a GP”.

Each one had to answer in no more than 250 words.

Results:
Nine participants from Italy, Portugal, Ireland, Spain and Poland, sent their thoughts and opinions. We remark sentences such as the followings:
- “You bring back home new useful ideas for your daily work” Virginia, Spain.
- “A constant whirlwind of ideas and feelings” Sara, Spain.
- “...having the chance to meet people who can share with you a different perspective on the same things you’re dealing with.” Elena, Italy
- “My participation was an example of organization, freedom, diversity and quality”

“This experience served to open horizons, often confined to our Health Centre or our City” Hugo, Portugal.
- “It broadened my mind and made me proud to be training to be a GP” Lisa, Ireland.

Conclusions:
No participant regret having participated in this Exchange; even more, this experience has enhanced forgotten positive aspects of being a Family Doctor. It helped trainees and First 5’s in being proud of their profession.
What does your GP mean to your health?
Rodriguez Benito Laura, Conde Valvis-Fraga Sara, Nieto Virginia

Background:
Our specialty in general medicine is the closest to the patient and although needs update scientific knowledge, nothing works without achieving a sincere and strong relationship and communication with our patients. But, how do our patients feel about our way of working? Do we know our patients’ expectations from us? Or even, do we know theirs? We are used to do quantitative research, which it is surely important to improve our daily practice. But we sometimes forget that qualitative studies could help us with the psychosocial aspects of the consultation.
If we were able to enhance this sphere of the investigation, we could practice our GP duty in a more effective way. What is even more important, we could improve our patients’ expectations: our final target.

Objectives/aims:
This study tries to get patients’ feedback about what they expect from their GP.
The specific objectives are:
- Getting to know what are patients’ expectations from their GP’s daily work.
- If there were any difference, do a comparison between patients and GPs’ expectations.
- Find out possible reasons that could explain that difference: Cultural, social or economical characteristics from the population; gender, age, presenting complaint, place where the patient is tested (close to a hospital or health centre), location (rural or urban area) etc.
- Find out if patients feel any difference between the attention provided by hospital specialists and GP’s?

Methods:
Display a test that will take place in different countries: close to hospital, health centres or even apart from sanitary services (leisure time places) to people.
The test will be divided into two parts:
- Socio-anthropological information: including patients’ age, gender, living place, kind of illness why they consult for etc.
- Patients’ opinion: A couple of easy understanding questions that will give answer to th objectives described above.
The study will take place in a period of time of 3 months.
Can’t get enough of VdGM?
Tell your friends and let’s meet again in July 2014 in Lisbon, Portugal!

http://vdgm.woncaeurope.org/content/preconference-2014-lisbon

WONCA Europe 2014 will be held in Lisbon. From the 2nd to the 5th of July 2014. The preconference, organized by the Vasco da Gama Movement, will take place from the 1st to the 2nd of July 2014.

Portugal is happy to receive the WONCA Europe Preconference in such a special year. We are celebrating 10 years since the foundation of the Vasco da Gama Movement - the WONCA Europe working group for new and future General Practitioners.

Taking this in consideration, the 2014’s preconference imported its main theme from the WONCA 2014 Conference: NEW ROUTES IN FAMILY MEDICINE.

Portugal is known throughout its history for opening new worlds to the world. This enterprising and adventurous spirit will surely be inspiring for all the young GPs from around Europe, encouraging them to participate actively in this landmark event.

In the preconference we will discuss the last 10 years of the Vasco da Gama Movement (VdGM). It is important for all of us to understand what has been done, what were the main difficulties and the main successes of this group. Realizing its objectives and its purpose, it is important to raise awareness amongst young GPs to the different areas in which they are summoned to help the VdGM.

Surveying the movement’s history and looking into its future, young GPs are also asked to give their contribution to the different “routes” we want the VdGM to travel within the next 10 years. Consensus on the objectives of the group in the future are essential, if we are to keep all our efforts efficient. It’s a decisive moment in VdGM’s history, and we are inviting you to be a part of it.

Groups will be made to discuss all these themes and their work will be shared. We will then proceed to attempt a consensus declaration on the objectives of the VdGM and General Practice/Family Medicine for the next 10 years.

Because we, GP trainees and young doctors, believe we have an essential role in the development of Family Medicine, let’s make our voice strong! Let’s make our voice one!

We are preparing a unique, innovative and enthusiastic preconference! Come and join us! Your participation is very important to us!

The Preconference is open to every trainee or new GP/FP, up to 5 years after his/her qualification, who wishes to participate. However, there are 85 places available and registrations will be carried out in a first-come, first-served basis.
Please note that even though there is no selection of the participants, we highly recommend that they will be trainees and junior colleagues who haven’t been in touch with VdGM and the WONCA family yet.
The registration fee for the Preconference is €65.

Deadline for registration: 20th April 2014.
You can register by following this link: http://www.woncaeurope2014.org/en/content/vdgm/registration/registration-fee.html

Please don’t hesitate to contact us for any questions by e-mail: preconference@vdgm.eu
There are significant inequities in the European context, which also afflict our discipline and prevent many trainees and junior General Practitioners / Family Physicians (GPs/FPs) from joining the annual Preconference and the WONCA Europe Conference. The Vasco da Gama Movement (VdGM) would like to aid them actively with the introduction of the VdGM Fund. Launched in 2012 at the initiative of the VdGM Past President Sven Streit, the Fund has already helped 6 junior GPs/FDs to attend the Wonca World Conference in Prague through bursaries.

**HOW CAN YOU HELP?**

Tell your National College, Scientific Association and Junior GP/FM Association about VdGM and the Fund. Encourage them to donate even small amounts of money to the The Vasco da Gama Movement Fund.

If you wish to make a donation, please consult the policies document and contact us at info@vdgm.eu. We will be more than happy to guide you and provide any information!

Thank you also for buying a special „I Support the VdGM Fund“ badge available at the 1st VdGM Forum in Barcelona and at the VdGM Preconferences!
The name of the great Portuguese explorer, who discovered the sea route towards India almost five hundred years ago, has been employed by the Vasco da Gama Movement (VdGM), the working network within WONCA Europe, dedicated to trainees and junior General Practitioners / Family Physicians (GPs/FPs). As they set out for their own exploratory voyage in the discipline of General Practice / Family Medicine (GP/FM) in Europe, the Movement functions as a communication platform and encourages their first steps by providing support and information.

Since its inception in Lisbon in 2005, links have been established with most GP/FM associations to create a European Council of representatives. Each year VdGM hosts an international meeting, known as the 'pre-conference', which takes place a day prior to the WONCA Europe conference.

The Movement has five working theme groups (Education & Training, Exchange, Research, Beyond Europe and Image) that constitute the pillars of its initiatives. These often work in collaboration with their equivalent WONCA Europe special interest networks. Some of the activities of the theme groups include the improvement of the quality of GP/FM training programmes, the establishment of a network for research projects and the promotion of Rural Medicine.

Moreover, the Junior Researcher Award has been launched following the movement’s continuous effort to promote a new generation of FPs that combine clinical work and research. VdGM also offers the unique opportunity for trainees and juniors to spend two weeks with a GP/FP from another country through the Hippokrates Exchange Programme. The most formative exchange experiences are awarded with the Hippokrates and Claudio Carosino Prizes each year.

Furthermore, our Movement has established the VdGM Fund, which was born from the observation of the unbearable inequalities and the on-going economic crisis, which afflict our continent and prevent many colleagues from joining international activities. Thanks to generous donations, VdGM has managed to offer bursaries in support of young and future colleagues.

Our mission is a global one and entails the foundation of a forum for collaboration to improve GP/FM. Through our activities we aim at empowering the future generations of GPs/FPs to lead the development of primary health care at a regional, national and international level.

For more information on VdGM activities, please visit

www.vdgm.eu

and follow us on

Twitter @vdgmeu

Facebook www.tiny.cc/facebookvdgm

Linkedin www.tiny.cc/invdgm

Youtube www.tiny.cc/vdgmtube

Flickr www.flickr.com/vdgm
THANK YOU

VdGM wishes to express its gratitude for the help given in creating the 1st VdGM Forum to WONCA Europe and semFyC

Wonca Europe - European Regional Branch of Wonca

Wonca Europe is the academic and scientific society for general practitioners in Europe. It has 47 member organisations and represents more than 75,000 family physicians in Europe.

www.woncaeu.org

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Spanish Society of Family and Community Medicine

semFyC is the federation of the 17 Societies of Family and Community Medicine which exist in Spain and represent over 19500 family doctors. It is organised in vocalías, sections, committees, working groups and specific programmes.

www.semfyc.es

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